



phoenix Rising

THE VOICE OF THE PSYCHIATRIZED

Smalls
October 1987
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HOUSING OPTIONS

Getting Walter
Out of Queen Street

Channon Court:
A Boarding House
Renewed

ROOMERS
DEMAND
RIGHTS

At Last,
Protection
for Roomers

PROTECT YOURSELF FROM PSYCHIATRY

If you live in Ontario, are over sixteen, and are deemed "mentally competent" by a doctor, you can appoint a personal representative who can refuse psychiatric "treatment" on your behalf (or permit disclosure of your clinical record) in the event that you are subsequently found "incompetent." The document below can be used as a sample appointment form. You, your representative and your lawyer should each keep a copy of the form). It is also a good idea to obtain a letter from a doctor (if at all

possible, a sympathetic psychiatrist), stating that you are mentally competent (as in the sample letter below). If you are in an Ontario psychiatric facility, pre-printed forms (Form 44 under the *Mental Health Act*) are available. A lawyer or patient advocate can help you fill out the form. Your own form and letter must of course use details from your own background, and your own wishes concerning "treatment" – the following are just examples.

SAMPLE FORM FOR APPOINTMENT OF A REPRESENTATIVE

To whom it may concern:

I, _____ (your name) _____, of _____ (address) _____, _____ (city) _____, _____ (province) _____, appoint my friend, _____ (representative's name) _____, who lives at _____ (address) _____, to be my personal representative under Subsection 1b(1) of the *Mental Health Act*. _____ (representative's name) _____ is willing to act on my behalf should I be found incompetent to provide a consent(s), as may be required under the *Mental Health Act*, to treatment, or to the disclosure/examination of my clinical record.

I am over sixteen years of age and believe that I am competent to appoint a representative and make decisions on my own behalf, particularly with respect to psychiatric treatment.

My wishes with respect to treatment, and I so instruct my personal representative (or other person who may be called upon to make treatment decisions on my behalf), are as follows:

- a) It is my firm wish that under no circumstances is ECT to be authorized for me.
- b) It is my firm wish that under no circumstances is any neuroleptic treatment is to be authorized for me.

In the past, such treatments have not proved to be beneficial for me.

Dated this _____ day of _____ (month) _____, 19__.

(witness signs here)

(you sign here)

SAMPLE LETTER FROM DOCTOR

(date)

To whom it may concern:

On _____ (date) _____, I examined _____ (name) _____ and found her to be mentally competent. In particular, it is my opinion that she is mentally competent to appoint a representative and to make decisions regarding medical treatment of herself and that her expressed wish that _____

_____ has been arrived at rationally, and on the basis of considerable information concerning these modes of treatment.

(doctor's signature)

(doctor's name)

ANK OF COM

WHAT KIND OF HOUSING DO WE WANT?

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EDITORIAL

The theme of the Toronto Regional Workshop on Homelessness (funded by the United Nations' International Year of Shelter for the Homeless) was "involving consumers themselves in policy-making regarding homelessness." The question this raised in my mind was: what, exactly, is a homelessness consumer? I was reminded of the bizarre term "mental health consumer."

The workshop split up into small groups to discuss issues of homelessness and housing. My group, like the rest, was almost entirely composed of social workers prattling about their unfortunate clients: "the homeless," "the underhoused," "the hard-to-serve," etc. One of the few non-professional participants, Frances Rukavina, then spoke up: "I'm old. I was an immigrant. I had no schooling, and lived in slums. My idea of fun is different from other seniors'. Everyone has their own life and their own opinions. So don't tell me what I can or want to do - let me tell you."

There was an unresolved argument between those (including myself) who felt that, when you identify people as having "special needs," you pathologize them and create a problem, and those who felt that "special needs" housing was obviously a must.

Here is what Rukavina had to say about the government deciding what people's "special needs" are: "They're going to label us and label us until we're in a box, and then they're going to label us 'dead.'"

When someone said that people have to work in coalitions, Rukavina commented: "Social workers come in and take your group away from you. I hate the word coalition. Don't let people take over running your group."

One of the social workers brought up the issue of burnout, stating that, "You can't commit to a community issue for more than a couple of years." Then Rukavina let loose a real zinger: "I've been doing it for 60 years, and I'm still not burned out."

The social workers changed the subject.

Later in the day, housing minister Alvin Curling gave an appalling speech, asserting that "You say politicians don't have the political will, don't have the guts [to do anything about homelessness]. No. It's *you* who don't have the will and the guts." He then made a hasty departure.

The audience was allowed to rebut Curling once he was no longer there. One woman pointed out that homeless people need guts and wits just to survive, adding that it was easy to "become 'clinically depressed' when you have nowhere to go and nothing to eat. Then they put you in the bin and pump you full of drugs."

People who are psychiatrically labeled must be allowed to make our own decisions about where and how we want to live. Let's take some advice from Frances Rukavina: let's stay away from social workers, and insist on not letting anyone tell us what we want or need.

- Irit Shimrat, Editor

Corrections

Apologies and thanks to Chris Reed and Kristine Starr Eglis, whose fine drawings appeared on pages 1 and 38, respectively, of the June 1987 issue: these artists should have been credited in the list of contributors on page 2, and were not.



phoenix rising

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Phoenix Rising assumes that any correspondence sent to us may be printed in "Write On" unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed.

No jobs for the psychiatrized

As an inmate for one year out of the past eight, I have a resumé that reads "Disabled." I don't mention diagnosis and, when asked to explain, I merely reply, "My body chemistry has malfunctioned due to pressure." This has been unacceptable to most employers, and my employment record shows no work since my incarceration for psychosis in 1979. An alternative would be not saying anything about the problem I'm labeled with – but the eight years of unemployment are a glaring inconsistency. And, being pumped full of neuroleptics and lithium, I probably wouldn't be able to work a 40-hour week.

So, my case can be used as an example of what we inmates face unless we take our savings and move out of the area, stop pumping pills, regain our energy, and seek work that is in our realm of using the head. With thoughts gained through our experiences, we should be writing, so we can advance our vocabularies, ideas, and contacts – maybe even do a newsletter. Bottom line: if you can't get work, use writing to make work.

Quality-control lacking
Yet it is inmate-written
Prison psychiatry "cracking."
We're labeled, authority-smitten.
Always sincere,

Bill Baker, Editor

Up Or Down, We Get Around

(Cowichan Valley Psychiatric League newsletter)

Duncan, BC

Finally found *Phoenix Rising*

I can't begin to describe it! It's wonderful: I've finally found you! I've been looking for *Phoenix Rising* for almost two years; ever since I got out of the hospital. When I first heard about you, I didn't know whether you published in Canada. Then I heard on a talk show (Speak-

WRITE ON

ing Out) that you were based in Ontario. For the last six months I (and my whole family too!) have been trying to find *Phoenix Rising* in magazine shops all over Montreal.

I am writing to you because I desperately want to find a patients' rights group (anti-psychiatry) here in Montreal. If anyone knows of such a group, or is interested in starting one, please get in contact with me.

So glad I finally found you!

Sincerely,

Linda Lee Ross

4310 King Street

Pierrefonds, Quebec

H9H 2E4

Canadian Gulag

I have been in a Canadian Gulag for 23 years. I have had 72 shock treatments, thousands of milligrams of drugs, and vomit from patients and shrinks alike. At present, I am on medication, for I have severe anxiety over all that has happened to me. I do not know if I would be further damaged by withdrawal from anti-psychotic drugs, or saved. There is nowhere to go for compassion.

The Clarke Institute really put it to me in '68, by keeping me for six months: drugging, shocking, demeaning me and my work. They burnt me out. You know what it is like to live with drugs.

At Mount Sinai in '76, there was a screw-up in ECT. I was paralyzed and suffocating. I spent three years in bed. No work, nothing. Just hanging on to the lake out the window. There was a fanatical occupational therapist who made me play games in the hottest sun, on pavement, in a hot

bathrobe. I thought if I didn't get the horseshoe over the peg, the world would end.

After a year, I became the success story of the Health and Welfare Department by topping university while loaded with drugs. Too bad I let them down.

At present a doctor, Edred Flak, is being investigated on my behalf. He and another shrink put me on lithium, which resulted in three months of migraines. They thought I had a kind of mania rage; not *righteous* pain and rage over all that had happened to me.

It was none of Flak's business to change my thinking patterns and give critiques of my writing. He interfered with my creative work in every way, even attempting to stop some of it. In Mount Sinai in '85, Flak said, "Don't you think you should concentrate on being a good person, not an artist?" I am a good person. And my art, despite him, saved my life. But I have been stripped of privacy and friends.

Too bad I still have to prove myself.

Too bad I have to write this.

Too bad Flak said, "What would you say if I told you it's good you listen to Pablo Casals and Bach at night?"

Me: "I'd tell you to go fuck yourself."

I performed enormous psychic feats to stay alive in '85. Flak makes me jump through fire *encore*. No braves. Just constipation.

Love,
Donna Lennick,
Toronto

Sometimes it's better to laugh

Thank you for showing an interest in the cartoons. (The cartoonist's name is Shawn.) They may not be an intellectual outlet for frustration, but sometimes it's better to laugh! We also cry, complain, sign petitions, etc – all to no avail. Even our patient advocate safely sits on the fence. We're so isolated out here and – being WLGs [people incarcerated under a Warrant of the Lieutenant Governor] – so scorned, that many things go unreported. Or if they are reported, nobody gives a damn.

Some fairly recent examples:

An elderly WLG complains of chest pains (A lot of elderly end up here.) He has a history of heart problems. He is laughed at by staff, wanders unnoticed off the ward the next day, and has a heart attack in a dirty washroom. Hurried burial, funeral service, no inquest.

An elderly patient on a geriatric ward complains to another patient of staff verbal and physical abuse, gross neglect, theft, etc.

A young patient complains to staff and is grabbed and bodily thrown by a nurse. The social work department investigates, and accuses the patients (including an old man in a wheelchair) of trying to beat up staff. Case closed.

Antagonistic staff write incriminating, damaging lies in patients' charts – especially right before a yearly review board – knowing full well the doubt, not to mention damage, this can cause someone who's otherwise doing well.

When I speak up for myself and my rights, this rigid, patriarchal institution labels me sick *and* defiant. Never mind that I've struggled to get sane and, now, to stay sane, as well as work in the community and come back to this place every day.

Some of us are attempting to transfer to larger city centres and, we hope, more

enlightened mental health centres. (Some hope, eh?!) But people should know what a hell-hole this place is. My heart goes out to the patients here who can't transfer anywhere, or haven't the will to try (the elderly and retarded, especially). One 79-year-old who'd been in Auschwitz told his board last year that all he wants is a decent meal before he dies. He told them he left the concentration camps only to enter this one. The board laughed indulgently at him.

What also concerns me is the typical civil servant's penchant for covering up, making no waves and, above all – Protecting That Job. Patient rights and advocacy ensure that physical abuse is "minimal" (harder to prove), but psychological abuse is rampant here. Doctors are abysmally inadequate. Over-medicating is the answer, for better control. When we try to improve conditions, Robert Cunningham, our administrator, accuses us of being manipulative and

trying to control the ward – that is, wresting control from the "pros."

A very small minority of the staff has been good. Some of these staff members have been hounded out of their jobs, falsely accused by other staff. Their crime: being supportive to patients like us: the "personality disorders," "schizos" and "psychopaths."

Thanks for listening.

Leigh

St Thomas, Ontario

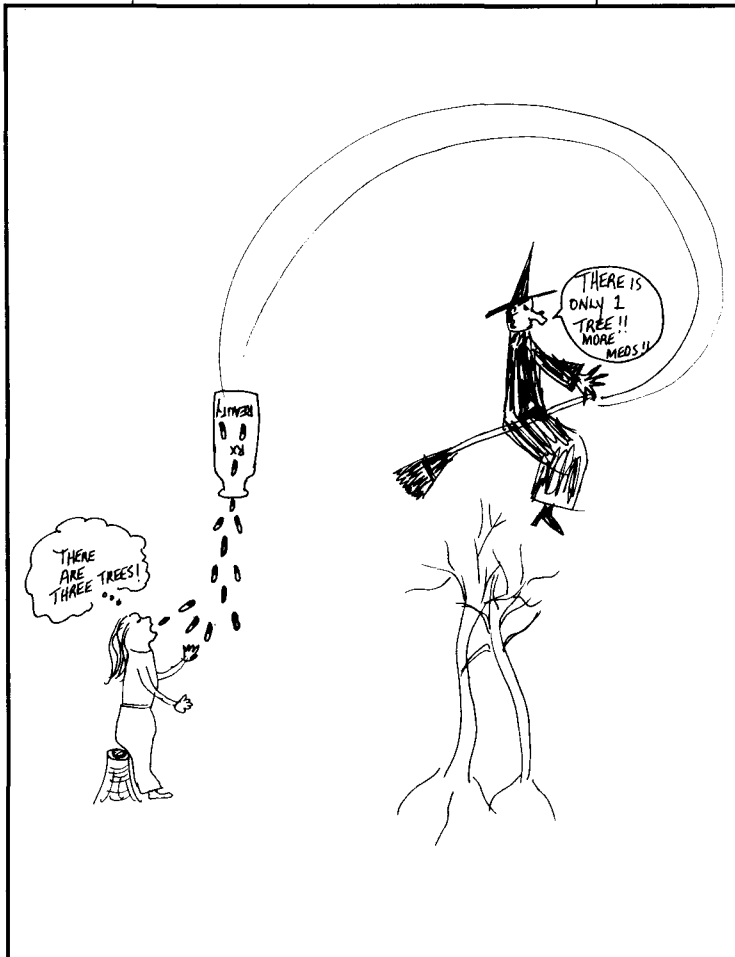
Military madness

What do the Vietnam veterans in Canada, the movie Hamburger Hill and the Contras have in common? They are all cards in the same suit, which the Pentagon is dealing from the bottom of the deck to turn up the winning hand in the game for Nicaragua.

Canadian vets, some sporting Purple Heart awards, newly surfaced as the forgotten heroes of the Vietnam war, insist they are *not* looking

for gory glory. They are just begging for help to pay their way to Washington for money to set up a network in Canada – to do *what?* Recruit for the Contras?! Stranger schemes have been concocted, and exposed.

Approximately 30,000 Canadian mercenaries – not draftees – wallowed in mud and suffered grotesquely alongside the GIs. To make sure we appreciate their heroic sacrifices, we are being deluged with the likes of Apocalypse Now, Rambo, Platoon, Full Metal Jacket and now, Hamburger Hill. All dedicated to those who died, 10,000 miles from home, to save the world for democracy. And those who returned with ill effects, and later fathered babies with birth defects, from having handled



defoliant such as Agent Orange – which was used to destroy four million acres of land and has affected the lives of nine million people in Vietnam.

Worst of all, this was happening on the wrong side of the border. No war pensions here from the American war coffers.

Michael Walsh, reviewing Hamburger Hill for the *Vancouver Province* September 1, wrote that “the real tragedy of ‘Nam [sic] was not the death and destruction. It was and remains the fact that, for the men who fought and the nation for whom they fought, ‘it don’t mean nuthin.’”

If “the real tragedy” was *not* the slaughter of innocent villagers by foreign troops sporting slogans like “death is our business and business is good” (and, for extra laughs, torching whole villages by setting thatched huts ablaze with their Zippo lighters), then it is high time Canadian audiences examined their own sense of values.

This recent spate of Hollywood movies must be recognized as the thin edge of the Pentagon’s wedge, as it rewrites history through the relaxing process of entertainment. The slack in critical reviews of Vietnam movies is matched by the lively publicity for this new Canadian Viet Vet show. That Canada was the only country to grovel to US pressure by voting against Palestinian self-determination should dispel any doubt as to who is calling the tune. What may not have been quite as apparent was how we were voting away our own right to self-determination.

If there is no hidden agenda to the network planned by the Vietnam veterans in Canada, let them openly declare themselves against the Contras, their counterpart in Nicaragua.

Claire Culhane

Former administrator of the Canadian Tuberculosis Hospital, Auang Ngai, South Vietnam – (1967-68), and author of *Why is Canada in Vietnam? The Truth About Our Foreign Aid* (NC Press, 1972)

TURKEY TAIL

This issue’s Turkey Tail goes to all the psychiatrists who testified before Ontario’s Standing Committee on Social Development that allowing inmates to refuse “treatment” would prevent said inmates from recovering from their so-called “mental illnesses.” These shrinks took the line that inmates whom they could not forcibly drug or shock would be “warehoused” in psychiatric hospitals, and would “languish without treatment.” Alas, one can do no more than hope that the terrible pressure of making all that money will eventually result in these people getting locked up, ruled incompetent, and forcibly treated themselves. (See “Rights and Wrongs,” pages 26-30).

PHOENIX PHEATHER

We proudly present the Phoenix Pheather to Toronto’s Roomers’ Association and the Coalition for the Protection of Roomers and Boarders, whose hard work resulted June 30 in amendments to Ontario’s *Landlord and Tenant Act* that will finally give some protection to roomers and boarders who do not share a kitchen or bathroom with their landlords.

These roomers and boarders are now protected from being evicted for fighting against illegal rent hikes, or for demanding repairs, or because their landlords want to sell. Landlords may no longer change the locks on roomers and boarders; this now has to be done by a sheriff with a court order. And landlords may no longer enter roomers’ and boarders’ rooms without written notice.

Roomers and boarders have been trying to get protection under the act for many years, and their organizing efforts and protests have finally embarrassed the government into coming through.

The coalition has plans to publish a book about the history of this rights struggle, and make sure that roomers and boarders are aware of their new rights.

Phoenix warmly congratulates the association, the coalition, and Ontario’s roomers and boarders. Let’s stay on the government’s back to make sure the new legislation is applied. (See “At Last: Protection for Roomers,” page 10.)

OUT OF THE ASHES

Ground Zero

Sometimes
the pain in my heart
is so great
I feel that an H-Bomb
is exploding inside me.
I feel I am
Jesus Christ –
Ground Zero
and God-centre of a new
Golden Age.
Then the pain wears away
and I become
just another statistic.

Al Todd

you can talk about the big buck
or talk 'bout being fucked up,
locked up, all dolled up or
'bout young boys being out of luck
what does it all mean my children
it means we'll be right back
going thru the rewind – again
trying to sort thru my mind
who was right and what was wrong
what really did happen and why
is all fair game in loving and this
my hopefully/hopelessly private
chemical warfare (where there's no DMZ)
days pass and pass us by
lying around, sleeping around . . . at home
crosswords, pleasant words
no words, closed doors
turn my back on fear and cry
travel out on pretense and hide
you can't hide black eyes, heavy sighs,
sleeping sleeplessly, the clang rhyme
i did not come to talk
what do i know
i come to make it here
with you, beside you,
on you, under you,
i come to take all of you
inside – i suck and cry
on your sheets, i burn
and dream of dying and
wake up clear and place
my ice cold nose in the warm
soft folds of your flesh
i remember protesting (and
now relishing) sharp bites
your mouth smiling
your teeth shining
in the streetlights
i remember hiding like a scared cat
back up against the wall and
wondering where the fuck is this at
and what road did i travel
to come
to this

Karen Deschamps

Notes from Inside

Lynda Nixon on why psychiatry doesn't work

Many times, I have come here to see many of the same old faces. Usually they are here for the same reason they came for initially, or a similar one: hopelessness; despair; confusion; pain. Nothing is ever really solved for them. They have come to believe that here there is refuge – a stop-over, providing separation and rest – so they can put off dealing with their situations. The patients *are not* being brought up to the level of being able to cope. Nor are they able to keep intact what intelligence they have left!

People get depressed from shock “treatment,” and lose their memory. But psychiatrists continue to give shock, because people are not responding to treatment for depression! Older people sometimes have a very difficult time after handling years of struggle and hardship. So why burden them with memory loss, of all ridiculous things! Psychiatrists and nursing staff know this, and yet keep collaborating in giving shock to older people and others. Pushing a button to send electricity through a person's brain is a bizarre and blood-thirsty experiment, and it doesn't work. And nobody ever hears about the deaths that occur as a result of shock.

The never-ending supply of anti-psychotic drugs and shock treatments unfortunately flows fast and easy. In a drugged stupor, patients stumble along the corridors, not having to reason or think. The sad fact is that many, when they return to our screwed-up society, will not be able to lead a normal or productive life.

Of course, they will leave here with prescriptions for more drugs in their hands.

After they get out, people waste their time attending so-called out-patient programs, day care, rehabilitation centres, drop-in centres etc. (I have been to many drop-ins, and it is not a productive way of passing time.) People come back into the psychiatric ward at least two or three times a year. Why?

The main reason seems to be that they have lost all self-esteem and given up hope. Psychiatrists tell many patients that they will have to keep taking massive doses of medica-

Why cover people's brains with a deliberate fog?

tions indefinitely. This means not being able to work, develop their lives, or find ways to be happy. Psychiatrists force a negative attitude on people by telling them they are permanently diseased, and causing them to become addicted to the drugs.

How can we diagnose mental illnesses when so little is known about the brain? Do not classify a patient as manic-depressive or schizophrenic. It sounds horrifying, and *very* permanent. How would *you* like to be classified? If you believe that you are disabled by a mental illness, how can you have hopes, dreams, or goals? You lose your energy, your stability, your self-assurance. Some patients commit suicide, because they don't want to live like zombies.

Like everybody else, the psychiatricized want work they can thrive on

and really enjoy. Why should their hope be taken away? Why shouldn't they have a chance? Psychiatrists could help people by decreasing their medications when they are progressing well, so that they can eventually get off the drugs and become their real selves. People on medications can't function satisfactorily. A monthly disability cheque is no substitute for a future. Why keep covering people's brains with a deliberate fog – a blanket smothering any chance of a different life? With medication and shock treatment, psychiatric patients do not stand a chance. Who knows what intelligence lies hidden in the minds of psychiatricized inmates? They may one day become a great asset to society!

Does not the idea strike you that, when patients are hospitalized again and again, the drug industry is making billions – and making psychiatrists richer than they already are – by ensuring a steady clientele?

Modern psychiatry is long outdated. Disrupting people's lives is its preferred method. Look at the results! People are classified as disabled, and their lives are wasted. Let us please not have to keep suffering through the old, worn, ineffective ways. The build-up of toxins through constant medication, the needles, the horrific nightmares, the awesome side-effects, the gruelling shock treatments cause endless, needless pain. If these methods are so great, how come our psychiatric units and psychiatric institutions are always packed full of inmates?

Getting Off the Street

Maggie Tallman talks to Alf Jackson about his work with street people . . . and his own experience as a street person.

How long have you been looking at the housing problem, and what have you seen happen?

Well, I've been around since they were moving people out of the inner city and shoving them all up to the suburbs. And the people didn't care for it. A lot of them have been drifting back downtown, or trying to. That's where most of them were born and raised. Only now there's condominiums all over the place, and there's no room for someone who's working for \$4.55 an hour, who just can't pay high rents.

We had some cold winters. One winter it was twelve degrees below zero, and I was picking guys up off the street; guys sleeping in garages and backs of cars. Sometimes you have to be careful – you wake a guy up, and he's liable to come up fighting. I had a few scrapes myself. I made it to the hospital, a couple of

for the night. Sometimes I'd get them into a flopt. Usually paid for that out of my pocket. There were a few places I knew. Or sometimes I let people stay at my place. I still do that. But what I want to know is, why should people be sleeping out in the street, or in public parking garages? Or freezing to death in a truck, like Drina Joubert? Hostels aren't the answer, either. If you have six, or eight, or ten, or 20 in a dorm, do you want to strip all the way

down, go have a shower, come back, and find your stuff is gone?

I think we should put up a lot of small bachelorette apartments, in a hurry. And give people their own room, with a key, even if it's just for the night.

You've lived on the street yourself, right?

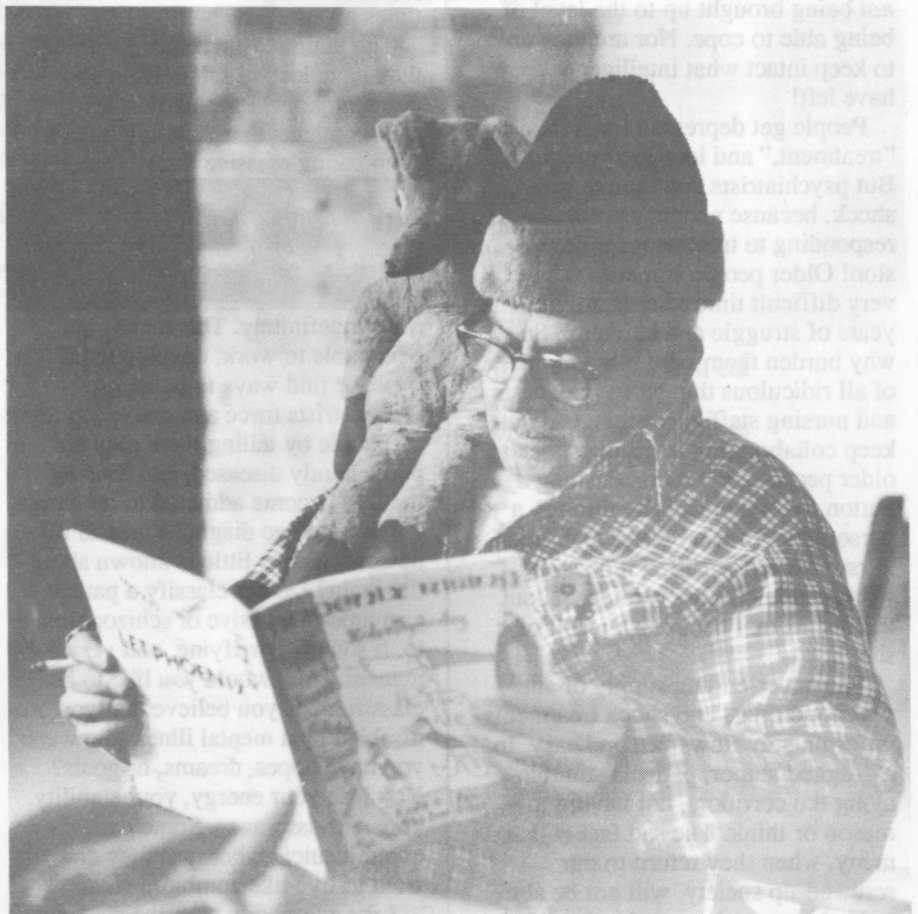
Yeah, sure. In 1954. After the wife died, I kind of got disillusioned. Fed

Some people were there by choice – you have to look at that, too. Some people don't want to live in places the social workers find for them.

times. But it was usually okay once the guy realized ...

Where did you end up taking people?

I'd send them to Fred Victor Mission [a men's hostel]. Keep them warm



up. She'd been in hospital for about seven years. I could have had a job at that time, if I'd wanted to. But I got into the booze. Later I jumped a freight and rode out west, to Winnipeg, where I did get a job.

But before that I was living on the street. And I found out what the other people there were doing. Some people were there by choice – you have to look at that, too. Some people don't want to live in places the social workers find for them.

I once saw a little set-up in Edmonton, which I thought was pretty good. This woman, Helen, would bring people in; mostly Native Canadians. She'd never ask anybody anything till they'd had the coffee and sandwich she'd give them. And then she'd sit and get them talking about the immediate problems they were having, that day.

I was on the bus one day, and I overheard a woman say she'd got a

The person they talk to should be another street person, not a professional. Someone who's been through the fire, and knows.

roomer in – a man who, I happened to know, had been talking to Helen and had decided to get a room. Helen had talked to the landlord. She liked to get the people room and board, so they'd have something to eat.

One concern that is close to home for us is the problems of ex-psychiatric inmates. I know that some members of On Our Own are homeless. Most are living in pretty sad situations, and paying rent out of their social assistance or disability cheques, which sometimes go directly to the landlords.

Preventing people from going into hospital in the first place, having them stay out in the community, is a step in the right direction. If someone



is stuck and needs a place to stay, there should be people in the community who will take them in.

The Roomers' Association people are very visible. And most of them have probably never spoken in front of more than three people before – usually their kids. But they are the ones whose immediate problem is that they don't have a home. Who will probably never have a house, and will be lucky if they ever have their own apartment.

I've got to hand it to the people who speak up, who aren't professionals. We have to have a place where people can at least go and have a cup of coffee and discuss their problems with someone. And the person they talk to should be another street person, not a professional. Someone who's been through the fire, and knows.

People who own houses don't want places in their neighbourhood where tenants come and go. Certainly they don't want a house that the landlord doesn't care about, that's going to become an eyesore. Groups of people have to be able to buy houses themselves, and keep them up. Then the neighbours know that they care about their own house, and about the

neighbourhood, too.

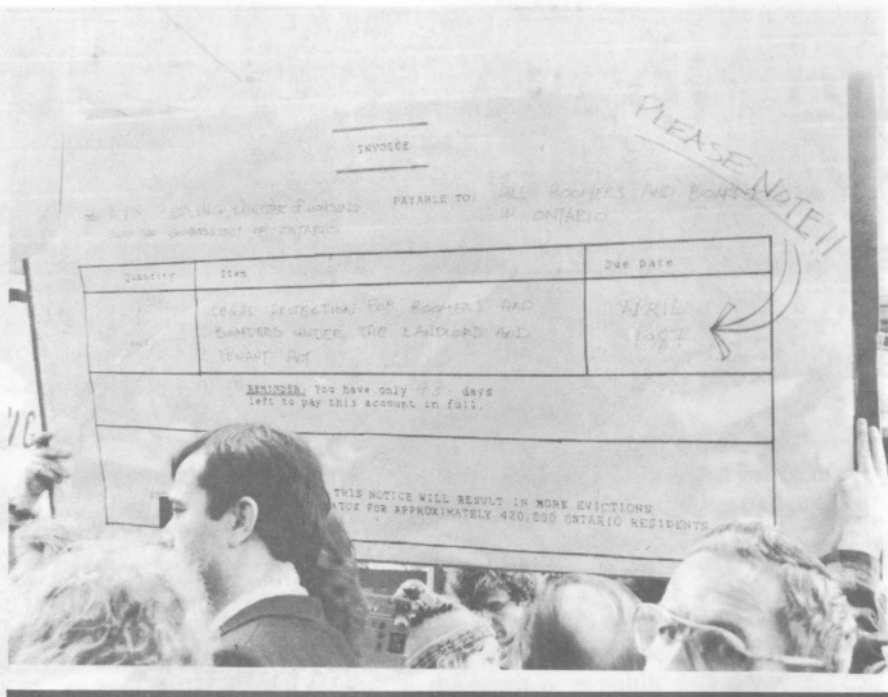
Right now, people coming out of institutions hardly have anywhere to go, and don't know what to do. They're often in no shape to do anything.

How do people live on the street?

Well, we have one thing in Toronto that's good. There are places people can go to eat. And usually, when you're on the prowl all day long, you're looking for a safe, warm spot to spend the night in. You might go to the Scott Mission in the morning for toast and peanut butter and coffee, then start your daily trek, and end up at the Good Shepherd Refuge for a late feed.

Many of the people living on the street are Native Canadians who come here from reservations, and find themselves shunned by everyone. To me, that's the biggest crime in this country. The people who are comfortable, who have good jobs, don't take the time to look at their brothers and sisters who are on the street.

Alf Jackson is president of On Our Own, Toronto's self-help group for ex-psychiatric inmates, which publishes Phoenix Rising.



At Last: Protection for Roomers

by David Reville, MPP, Riverdale

Amid the partisan catcalling that seems always to accompany the end of a legislative session, there was a little oasis of calm. Bill 10 – *An Act to Amend the Landlord and Tenant Act (LTA)* – received third and final reading in June, without amendment and without debate. In the mainstream media, Bill 10's passage received only a mention. For the Roomers' Association and the Coalition for the Protection of Roomers and Boarders, however, Bill 10 is cause for rejoicing: it means the inclusion of roomers and lodgers in the LTA.

My own involvement in the roomers' rights struggle dates back to 1972, when I helped found Neighbourhood Legal Services, which was helping roomers get organized so that they could protect their rights. Trouble was, they didn't have any ... they'd arrive home to find their belongings on the street, and the lock changed.

Roomers who lived in privately-owned rooming houses were still at the mercy of landlords who responded to an ever-tightening housing market by raising rents and by

speculating. Each rent rise and each flip created casualties. As the housing crisis deepened, eviction from a rooming house often meant homelessness. Because roomers weren't specifically mentioned in the LTA, they could be evicted without cause and without notice.

I drafted a simple amendment to the LTA to include roomers and boarders – Bill 10. The bill passed on second reading, the Conservatives voting in favour and the Liberals against. I was delighted and surprised when my motion to send the bill to committee for public hearings carried. On the same day Cam Jackson, the Conservative housing critic, tabled Bill 59 – which would have exempted people in certain housing situations from the LTA. Because his ballot item had already been debated, there was no chance that Bill 59 would be dealt with. So the tabling of Bill 59 was just a statement of the Conservative position on roomers. The really surprising move was made by Attorney General Ian Scott, who tabled Bill 87 – a government bill – on June 17, after the public hearings on my bill had concluded. The press

went wild with speculation on just what the Attorney General's intentions really were. Was the government going to kill Bill 10 and let Bill 87 gather dust? Were roomers going to have to wait? How many would survive the summer recess? Would there be an election, and would a new government give roomers a high priority?

Roomers and roomers' advocates went into heavy strategy sessions. In the end, we decided that we'd play it as though everybody wanted to protect roomers, and the difference in approach could be resolved. Imagine our surprise when that's precisely what happened! In committee, Bill 10 was amended and unanimously supported. It did come back to the House, and was carried, again unanimously.

It's unusual for a private members' bill to pass into law. Why did Bill 10 pass? It's not as though the problem suddenly became clear to the legislature. There had been pressure to include roomers in the LTA for years. A long line of NDP housing critics had pummeled ministers of housing about roomers' rights. An equally long line of coroners' juries recommended protection for roomers.

Housing activists had raised the plight of roomers throughout the 1970s and 1980s. The Christian Resource Centre got involved with roomers in both public and private sector housing. The community legal clinics – principally Neighbourhood Legal Services and Parkdale Community Legal Services, have played a role in organizing roomers and going to court with them – often in losing causes because roomers weren't specifically included under the LTA.

All that history is part of Bill 10, but doesn't explain why protection for roomers was available in June 1987 and not, say, in February of 1974 or September of 1982.

I've been part of many a long struggle, some as long as this one. I can't think of a victory that I savour more. Congratulations to the hundreds of dedicated people who worked over the years so that roomers could have the same protection from arbitrary eviction that other tenants have long enjoyed.

A Boarding House Renewed

The Houselink takeover of Channon Court

by Irit Shimrat and Ryan Scott



Lea Caragata is the executive director of Houselink Community Homes, an organization that houses ex-psychiatric inmates in cooperative houses and apartments, with the ultimate goal of independent living.

Houselink also runs Houserights, which fronts money to homeless people seeking rooms (so they can avoid the problem of not being able to get welfare because they have no address).

Caragata believes that "If you give people a decent place to live and control over their living space, the results will be astonishing." She does not believe people can get "rehabilitated" in a traditional, hierarchically-run group home.

In the summer of 1981, the residents of six Houselink homes were evicted so that the places could be converted into more lucrative rental properties. Since real estate speculation and rising rents were clearly going to make it impossible for Houselink to keep renting, the organization started buying housing stock. Houselink applied to Canada Mortgage and Housing, and got

money to start buying homes. (They are looking at buying about six sites in 1987.)

How did Houselink take over Channon Court?

In August 1986, Houselink put in an offer to purchase Channon Court, using Ministry of Housing funding. The original plan was to demolish the buildings on either side, move half the residents elsewhere, and temporarily house the remaining residents in the centre building (which would continue to be run by then-owners Atlee and Hall until the other buildings were rebuilt). The residents would then be moved into the side buildings, and the central structure completely renovated.

Seventeen Channon Court residents were moved to a privately run boarding house in another neighbourhood. Houselink applied to the Committee of Adjustment for exemption from several minor zoning restrictions that would prevent the planned conversion of Channon Court into apartments, and the committee ruled in the organization's favour. Some neighbours objected, and appealed to the Ontario Municipal Board.

Some housing activists also took part in the organized opposition to the Houselink takeover. Caragata feels that their main objection was that Atlee and Hall would continue to run the centre building as a boarding house until the work was completed.

In December, Channon Court resident John Dimun died, and the inquest into his death resulted in the end of Atlee and Hall's association with Channon Court (see "Boarding House Tragedy," Volume 6, Number 4). Houselink has since overcome the opposition, and reconstruction of Channon Court is well underway.

What about the residents?

Caragata says that Houselink is generally devalued by people who run traditional group homes, who feel that there are people who can't function well enough to run their own show.

The people who lived in Channon Court were seen by professionals as being "hard to serve," or "chronic." Caragata believes that, with the right kind of support, these people can learn to control their own place.

It took almost a year from Houselink's first negotiations with Atlee and Hall to its taking possession of Channon Court. But Caragata says that people have realized Houselink isn't the enemy; that their support always was for the people who lived there.

"If you give people a decent place to live and control over their living space, the results will be astonishing."

As of March, all the Channon Court residents had been rehoused in what Caragata says were "some not very terrific spots — standard boarding homes. A significant notch up from Channon Court, but far from

decent housing.” But the important thing, to Caragata, is that they began to believe they were going to have new places to live in, and be involved in the process of setting the places up: “It’s an exciting thing to see people who’ve never had a chance to have their own bedroom making decisions about how they’re going to live.”

All the residents will be returning to Channon Court, except one group of people who have decided they don’t want to move back to Parkdale.

According to Caragata, “There were about ten people at Channon Court who workers said did not know how to bathe themselves, had phenomenally poor hygiene, peed the bed – and it’s phenomenal how much that’s changed, in a different environment with different expectations. A man who has been bathed by staff for years recently looked up at a woman staff member and said, ‘Get out of the bathroom.’ Sometimes you have to tell him to go have a bath. And he will. He doesn’t need someone to do it for him.”

Another resident “had been written off – the file on this guy is just disgusting, just doesn’t acknowledge him in any way as a human being. And he sat at the organizing meeting last night and said, ‘You know, I used to be able to cook. So maybe I could do that again.’ And this is someone who wasn’t credited with the ability to put on his own clothes.”

What about staffing?

Caragata says that Channon Court won’t have staff in the group-home sense. “There won’t be any offices on the premises. Staff will be there as they need to relate to the people. There will be someone there at night. But the staffing will change as the need changes.”

There will be four five-bedroom apartments, three four-bedroom apartments and five bachelor apartments. The bachelors are designed for

people who have been violent and with whom none of the other residents want to live. The occupancy of all the units is being decided in what Caragata calls “a kind of collective process we’re going through with the residents.” Each apartment will have a kitchen, dining area, good-sized living room and two bathrooms, as well as a bedroom for each resident.

Caragata says that, as they learn to do things for themselves, “people will increasingly do without staff. Even at the beginning, there will be a couple of units that will only need intervention if there is a problem, or to help organize a special event.

“It’s the residents’ right to say, ‘Thanks, but we don’t need you.’ They need to be able to make staffing decisions themselves. There will be basic rules, but they will be decided by a process we call ‘social contracting,’ where we hammer out

“It’s an exciting thing to see people who’ve never had a chance to have their own bedroom making decisions about how they’re going to live.”

the rules with the residents themselves. And that’s got people excited. Although they don’t quite believe us yet. I think they believe we’ll introduce our own rules at the last minute.

“One of the biggest challenges is establishing trusting relationships. These people have been screwed around by the system, and mistrust it with good reason.”

Houselink finds staff by advertising. Caragata says that people are hired on the basis of their values, rather than for their training: “people who can be committed to supporting residents to make decisions. That’s difficult, especially for someone who comes from a social-work sort of background. A lot of people who apply come out of that background, but we tend to hire people who don’t

“Residents are really good at helping each other work things out. We expect people to be able to do that. It’s their house, and it’s their lives that are affected.

“Also, we don’t assume a crisis-like response. People are surprisingly able to deal with things themselves. These are people who have dealt with situations that I can barely imagine. As long as they know they have some kind of support, they’re far better able to deal with their own interpersonal problems than we are.”

What will residents be doing?

Most of the people at Channon Court, says Caragata, “have been through every day program known to man and, quite frankly, they’re not interested. I’d like to see people productively engaged, if that’s what they want.

“But getting a job is hard, for anyone. People with marginal employment histories are the last to be hired, and we try to be honest about that. We don’t want to give the impression that if they just get out there and hustle, they can make it. That does people a disservice. It makes them think the problem is *theirs*.

“One of the things that’s remarkable about many of the people who live in Channon Court is that they’ve decided to pass on the system. Some haven’t seen a physician for years. Some are not on any medications and don’t see any therapist.

“We support people who make a responsible decision to get off psychiatric drugs. We will not evict someone for deciding to stop taking such drugs. The choice is theirs, as long as they can accept the consequences. The people that person lives with set the standard for behaviour in that coop.”

Houselink doesn’t demand that people follow regimens. “What we provide,” says Caragata, “is *housing*. We try to provide it with as few ‘social service’ rules as possible. It’s not my business if someone goes off

their medication. It's only my business if they then threaten someone.

"Most of the people in Channon Court are on public trustee. And in a few cases we've said, 'Here's your money.' And three and a half minutes later it was gone. And it's going to take a lot of time for some people to accept the consequences of its being gone. So we have to support them in certain ways.

"An awful lot of people have 'inappropriate spending habits.' But that doesn't mean someone else should manage their money.

"People have the right to make decisions about their own lives. And the people in Channon Court can ultimately do that. We can't say, 'Here's the keys, you're all set.' The process has to be careful and supportive. People need the right supports at the right times. But they also need the luxury of making mistakes.

"Each Channon Court resident's rent will be 25 percent of their income – about eighty or ninety dollars

a month. So they'll be able to buy food. And if they don't want to cook, they'll be able to eat out. We were talking about helping people to cook at the meeting, and one of the guys

"We try to provide housing with as few 'social service' rules as possible."

said, 'Spare me. There's a little joint across the street. If all this big talk about rent is true, I'll go across the

street and eat three meals a day.' And that's fine.

"People will have enough money. Not for luxuries. But an adequate amount to live on. Especially given that there will be people around to help them buy groceries as economically as possible.

"Each resident will have a fridge in their own room as well as sharing the big fridge in the kitchen, and lots of people have no intention of shopping or eating together. Which is understandable. If you don't have much money, you don't want to put your three apples in the fridge where someone else might eat them.

"But people have made remarkable progress in the short amount of time they've been out of there. Not only in their abilities, but in their willingness to believe that there are some possibilities for their lives."



There's No Place Like Home

Maggie Tallman asked three members of Toronto's inmates' self-help group how they live . . . and how they'd rather be living.

Anonymous:

I'd been living in a rooming house with about fourteen other people, that I'd found through someone I met at an ex-psychiatric centre. (I lived alone before that, but I didn't like it.) Some of the other people in the rooming house were nice; some weren't. I got sick of the place because there were too many people; too many arguments: there was never any peace for more than a day or two.

Then Houselink [see page 11] had a vacant co-op – a unit in a townhouse. I've been living there for two years now. I like the privacy: I've got my own room. Two other people are living there. We have house meetings every two or three weeks. We're each supposed to be doing four hours' work a month in the community, but none of us do. I don't drink, but the other people do. But we get along alright.

One of the people who lives there is a good guy, but anti-social. He's an alcoholic; he drinks too much, and then smokes in his room. That could start a fire and burn up the whole place. I talked to a guy at work about it, and he said we should get rid of him. But we're going to give him a chance. He went to the Houselink drop-in today; he's starting to meet people a little bit more.

I gross about \$1,000 a month. The guy is on Family Benefits. He gets about \$400. He doesn't work; he just drinks. I think he gets money from his parents. The girl goes to school. Each of us pays \$200 a month. In other Houselink places, I think, your rent goes up if you're working. But not there. I get a monthly bus pass for five dollars, because I see a psychiatrist and I'm working. You have to work, or be in a program, to get that. I'm on medication. The girl's not. I don't think the guy is; he wouldn't be able to drink that much.

At the rooming house you pay about \$140 a month in rent, plus 70 to 90 dollars for food. This place costs a little more, but it's worth it. You can have your friends over. We got a TV for free. We saved some money and got some chairs and paintings to put on the wall – I think Houselink helped out with that. Buying a bed is up to us, though. I can't afford one; I sleep on a mattress on milk-cartons.

Ron Shanessy:

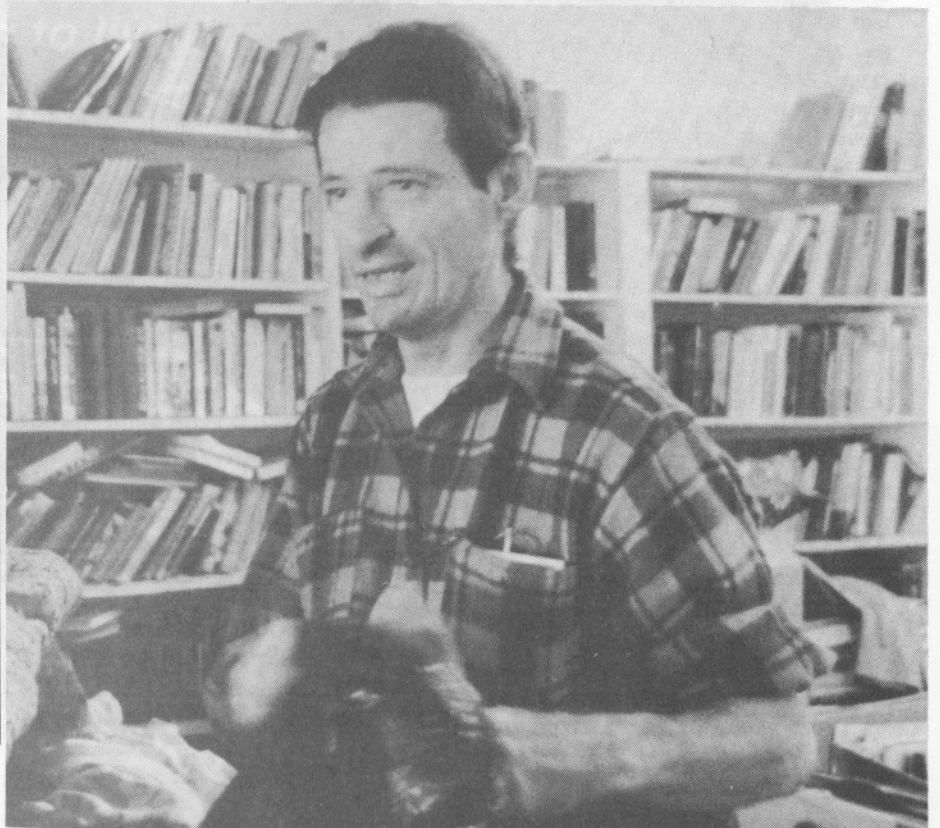
I'm living in a huge double house with about eighteen other people. Everyone has their own room. My rent is very reasonable, but I've been stuck in the same place for over 20 years now. It's getting a little bit confining. Junk keeps piling up.

You have to line up in the morning to use the bathroom. If anybody on the first floor is using water you don't get any on the second floor.

You're embarrassed to have people over because you don't like the look of the bathroom or the kitchen. And it's not your fault; it's the other people in the house. You may be out during the day, but some people are in the house all day. And when you come home, it's the same mess again.

After rent, I have \$40 a week. It's enough money to exist, but that's about it. I used to paint, but I can't afford art supplies. And I haven't got the space. I'm hoping that my doctor can get me on disability benefits, so I can improve my situation.

I wouldn't want to live in subsidized housing. I'd rather be in an area where I know everyone else isn't going to be in the same boat; where everybody isn't categorized as a little group. I think a mixed area's better, with some people who do have money and some who don't. It's not just the house you live in that can make you afraid – it's the area



you're living in as well.

It would be nice to have an apartment of my own, with my own bathroom and kitchen, and only myself to clean up after, not a whole bunch of people. I might live with one other person, if I could find someone to get along with. But after all this time living by myself, meeting someone is almost impossible.

Buck Jones:

I share a small room with four other guys in a boarding house. I pay \$358 a month – it just went up eighteen dollars. I don't know if the place is under rent-control, but I hope so. I've got a pretty good thing to go to on the twelfth: a roomers' meeting. I'm going to try and check it out.

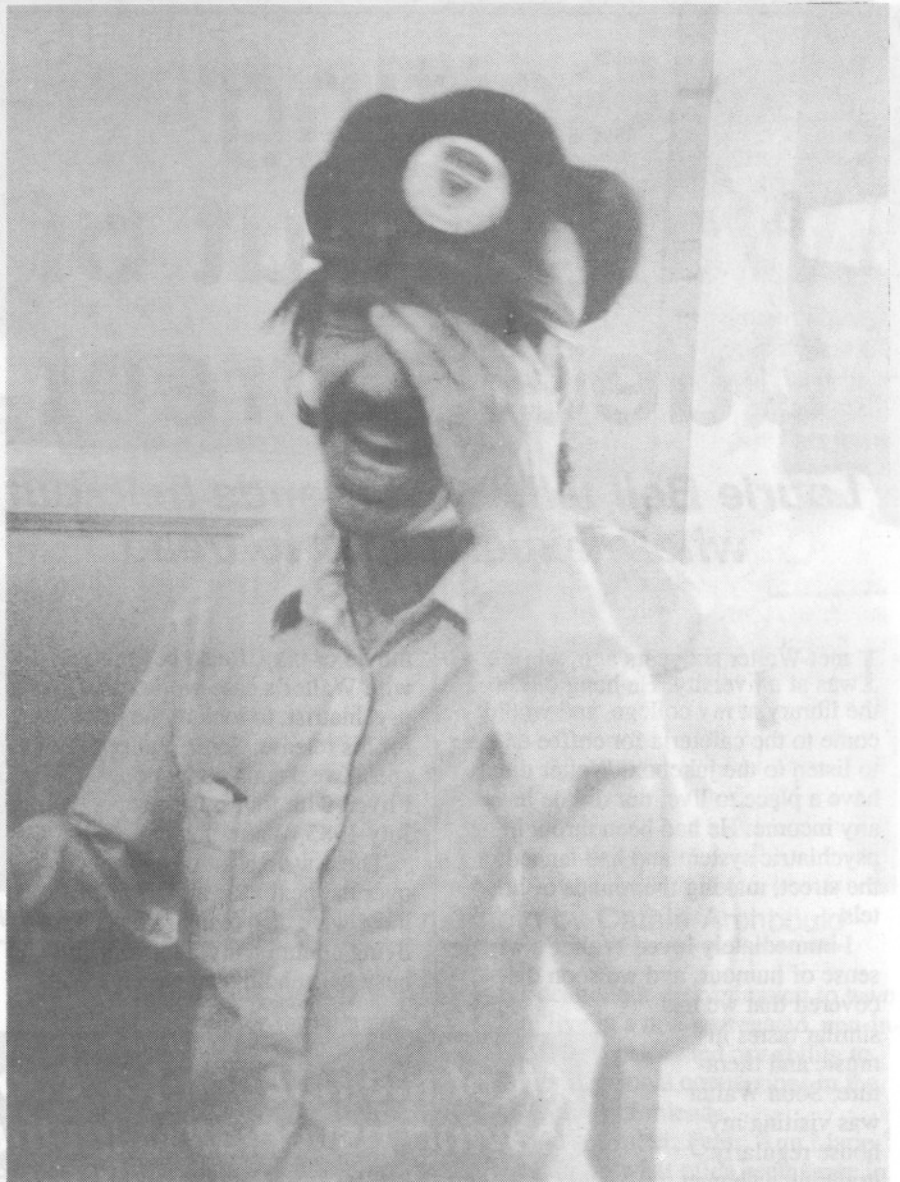
I had to come up with first and last when I moved in. I never see my cheque: it goes directly to my worker. He pays my rent. I go check with him every Friday, and he gives me fourteen bucks a week. I get the balance at the end of the month.

About 24 people live on the first and second floor of the house. Most are ex-psychiatric. Some come in off the street. Some of them sniff glue or smoke dope. They're not even law-abiding.

The landlady and the cook live on the third floor. The landlady doles out the pills every day. I don't take any. There's a lady who cleans everything and does the laundry. There's a few cockroaches, but it's pretty clean.

There used to be a TV, but not anymore. Sometimes I lose some clothes. Once, I got cleaned out. And there's no heat.

Sometimes the food's not good – sometimes it's cold. If you come in late for dinner, the cook won't heat anything up. She says the kitchen is closed after six. If I don't phone, they don't save my chow. Some people take seconds before you've even had yours; you've got to really



push your way around. I don't want to be pushed around like that.

This one guy beat up the cook because he wanted another cup of coffee. I said, "Hey, she didn't do sweet nothin'. What do you want to pick on her for? Pick on me." He tried to kill me last month. My worker says I could have laid charges. If he touches me again, I will. He's at the East End Detention Centre now, and I hope he stays there for life.

Once I went to a hotel downtown, where I was supposed to work for a room. I worked for 48 hours, washing the dishes, cutting the onions, this and that – but the man still wouldn't give me a room. Then I said, "Look, I'll bend over backwards for you. Just tell me what you

want done." So I had to go downstairs and clean out a place that was just filthy; it was wall-to-wall grease. I had to scrape the grease along the floor and shoot it out the back way. That's not for me.

I got one person I want to live with me. Her name's Clem. I'll take care of myself and of the lady. I don't want to go and apply to the city for low-cost housing if I can find a room on my own. I do it my way, or no way at all.

I had a dream one night that I was living out in the country with my woman: we'd just moved into this giant house. This thing had 192 rooms. And I said, "Hey. That's nice."

Getting Walter Out of Queen Street

Laurie Bell tells how friends help out where experts fear to tread

I met Walter six years ago, while I was at university. He hung out in the library at my college, and would come to the cafeteria for coffee and to listen to the jukebox. Walter didn't have a place to live, nor did he have any income. He had been through the psychiatric system and had landed on the street, making the rounds of hostels.

I immediately loved Walter's wry sense of humour, and we soon discovered that we had similar tastes in music and literature. Soon Walter was visiting my house regularly — grabbing a shower, a hot meal, a place to sleep; watching the hockey game. For a couple of years we carried on this way until, suddenly, Walter disappeared. He never came around campus, and he didn't come to the house. Nor could I find him at any of his other usual hangouts.

It was more than a year before I heard from Walter again. Finally he phoned from the Queen Street Mental Health Centre. Myself and three other friends from school, who were also close to Walter, started to visit him at Queen Street and to invite him home for dinner, or out to a

movie or play. I also began to meet with Walter's case-worker and psychiatrist, to look at the prospects for his release. Soon Walter began to spend weekends at my house, where I lived with four other people. And in July 1985, Walter moved in with us.

There were a lot of great times over the next year and a half. But there were also many things about living communally, in a very full and busy household, that weren't Wal-

All of the houses for people leaving psychiatric institutions had rules that would inhibit Walter: curfews, mandatory programs and mandatory therapy. We passed on all of them.

ter's cup of tea. In October 1986, he asked to be brought to the hospital.

Almost from the moment Walter was back in Queen Street, Nicki, Peter, Ann Marie and I, his closest friends, began to explore housing possibilities for him. The search for housing has been long and frustrating, but incredibly educational for the four of us. We have been brought face to face, not only with the

general housing crisis in the city of Toronto, but also with the discriminatory practices toward, and complete absence of housing options for, a person who has been psychiatricized and therefore carries around the label "mentally ill."

I want to outline our six-month search. It will be a familiar story to anyone who has been through this system. But it is also a bit unique, because Walter had four friends committed to finding him housing that he wanted. From what I could see, no one else on Walter's floor at Queen Street had anyone in their life who was doing this kind of legwork on their behalf. The last six months have given us an appreciation for people who are all alone in the psychiatric system. We know that, if it was this difficult for five of us working together, it is virtually impossible for someone who is completely alone, with no one to rely on except people working in the psychiatric system.

Walter told us that he wanted to live somewhere where he would be free to make his own plans, to come and go as he wanted. First we looked into a number of houses for people leaving institutions. All of these houses had rules that would inhibit

Walter: curfews, mandatory programs and mandatory therapy. We passed on all of them.

We had a meeting with Walter's case worker and psychiatrist, and a member of Queen Street's housing department. None of them had anything better to suggest than boarding houses in the Queen Street area. Walter had

already been that route, and it hadn't worked out. There were too many people forced to live in small, run-down quarters.

I contacted the Community Housing Support Service to see if they had any creative ideas. I was basically told that Walter had no choice but to live in a run-down rooming house. The worker suggested that a paint job and some pest control would make it



Left to right: Laurie Bell, Walter Murphy, Nicki Monahan. Photo by Cathie Archbould

bearable. When I said we wanted something better for Walter, I was told that our "expectations" were unrealistic. Rooming houses were supposed to be Walter's lot in life. The worker suggested that I was placing my middle-class values on Walter.

This infuriated me. It was Walter, not I, who had decided how he would like to live. And is it only middle-class people who want to live somewhere clean, and free of rodents and cockroaches? Is it only middle-class people who want a home they won't get evicted from at a moment's notice?

We finally gave up on the experts. We began instead to tell everyone we knew that we were looking for a place for Walter to live. It was only then that things began to come together.

Nicki, one of our group of friends, had a roommate move out of her apartment May 1. We got Walter discharged, and he moved in temporarily. Nicki and Walter shared the apart-

ment for two months. On July 1, Nicki was leaving for the summer, so I arranged to have someone sublet my apartment for two months, and moved into Nicki's place with Walter.

Meanwhile, a friend told us about a new building of bachelor apartments downtown, which would be run by Homes First, a non-profit housing organization for low-income singles. She introduced Walter and I to a woman who has been helping people who are presently homeless organize to move into the new building. Walter joined this group and, when the building is completed this fall, he will move into his own apartment.

Getting Walter out of Queen Street has been a maze of Welfare, Family Benefits Allowance, case managers and psychiatric assessments. More than anything, it's been a long search for housing.

I believe we were able to find good places for Walter to live because of our commitment to satisfy

his desire, our determination to have him live in a non-segregated, non-institutional place, and our ability to tap our personal connections in the community for leads.

Nicki, Walter, Peter, Ann Marie and I have what often seems rare in the world of psychiatric institutions: a strong, committed friendship. This helped us to overcome the many obstacles preventing people from getting good housing. We were able to do what no expert could.

We're planning to throw a shower and a house-warming party when Walter moves into his bachelor pad. It will be one hell of a celebration.

Big Brother's Place?

Investigation of a mass exodus

by Irit Shimrat

Bob was at Oak Ridge, Ontario's incredibly repressive prison for the "criminally insane," before he came to My Brothers' Place. Labeled "schizophrenic," he gets injections of Modecate once a month. Modecate makes him shake a lot (he was shaking during much of the interview), and doubt what he perceives. He thinks he would be "in a better state" without it, but is required – by court order – to keep taking it. He doesn't know for how long. He says that My Brothers' Place is "really nice," that he wouldn't want it to be any different, that all the staff are "really nice people" and that all the folks there are "family."

Each resident, says Bob, has a written commitment to report on anyone using drugs or alcohol in the house. Anyone using either can be "released" – that is, kicked out – immediately. (If being at the house is among the conditions of a resident's parole, being kicked out means going back to prison.) Most residents are allowed to come and go as they please, as long as they phone in if they're going to be out late. According to Bob, the house is "run by the men, not the staff."

My Brothers' Place is Toronto's halfway house for men who have been psychiatrized in prison and/or locked up in high-security psychiatric institutions (see Volume 6, Number 2). Funded by the Ontario Ministry of Community and Social Services, the Ontario Ministry of Corrections, and the Correctional Service of Canada, the house opened in 1985. It has had an excellent record: men who've lived there have either not gone back to prison (or "hospital") at all, or have stayed out much longer than ever before in their adult lives.

This year, half the counselling staff and several members of the board of directors left My Brothers' Place, as the result of insurmountable political conflicts. All the men who lived there at the time of the mass resignations are also gone.

My Brothers' Place is an ordinary-looking downtown residence. I talked with Carolyn Crane, the administrative director, in her office on the second floor. While we were in

This year, half the counselling staff and several members of the board of directors left My Brothers' Place.

there, people kept knocking on her door, asking for this and that: tobacco, a dictionary, keys.

All residents of My Brothers' Place attend group and individual counselling sessions. "Having continual problems with not being able to control impulses" was Crane's example of an issue that might come up. And the counselling "changes to meet the needs of the population."

Apparently, it also changes to suit the agenda of the board and staff. Staff members who resigned say they were asked to "tone down" their anti-psychiatry, politically-oriented coun-

selling, which included "discussions about sexuality, psychiatric labels, and where the oppression in prison is coming from" – and information about the need for, and the procedure of, withdrawing from psychiatric drugs.

Crane told me that such information "is passed on to new men by those who are already here. So it would never be necessary for staff to bring it up." But when I mentioned to Bob that psychiatric drugs are dangerous, it seemed to be news to him.

At a weekly staff-resident meeting, said Crane, residents can bring up policy issues, such as whether the front door should be kept locked: "There's only one staff on the weekends, and they come up here [to the office] to do work. In theory, people could walk in. Residents, friends ... who knows? We began to think that maybe, just for some safety, we should lock it." Residents do not have keys to the house, and cannot lock the doors of their rooms.

Crane says My Brothers' Place tries "to keep as few controls on the men's lives as the law allows. Some of the federal men have conditions that we have to impose – like knowing their whereabouts at all times. But we try to maintain the attitude and atmosphere that this is a home. And we are, in a very real sense, a family. We generally try to measure everything against whether it would happen in someone's home, and to ask nothing more than a family would ask."

Another condition, recently imposed by one of the house's funders, is that residents cannot have overnight guests. "We can't fight it," says Crane. "If we did, they could pull their contracts. We're all very unhappy about it."

But according to Ruth Morris, chairperson of the board, several board members, including herself, had never approved of “conjugal overnight visits” in the first place: “Sexual promiscuity, which it has to be – I mean, we’re not talking about long-term, lasting emotional relationships – is not necessarily the healthiest way of establishing relationships in life. We’re trying to help people learn social skills. Just going around sleeping with a different person each night is not really the way to develop an attitude toward sex as not purely an exploitative thing of treating the other person as an object. The house isn’t the only place, nor is night the only time. And there’s nothing to stop the person from getting married.”

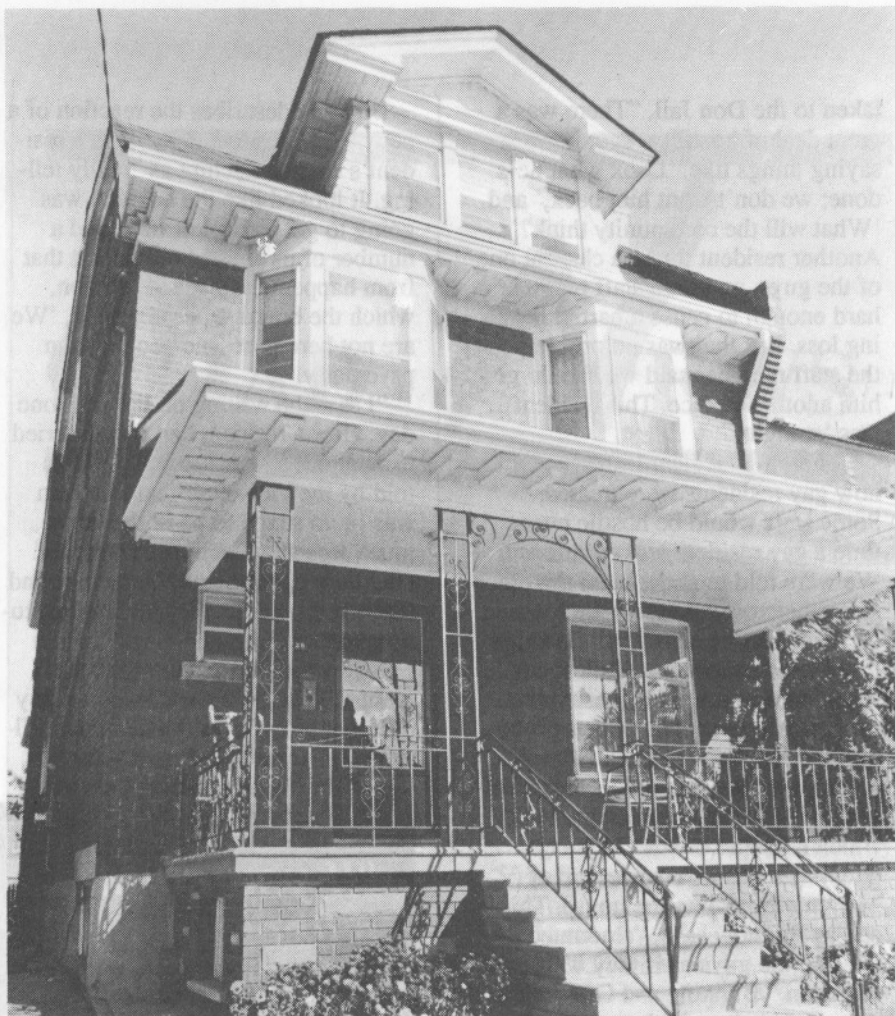
There is if the person is gay. Besides, why should anyone decide for someone else that it is only okay to have sex within a “lasting emotional relationship”? (Yet this is what families do.)

Carolyn Crane said that, while she is “personally angered by some of” the rules she is forced to obey, she guesses that they are “part of the ‘normalization’ process. These men have always defied the rules. That’s why they’re here. And we’re beginning to recognize that there are some rules that have to be acknowledged. It’s part of the reality of living in this society. I mean – let’s face it – this is not the ideal society.”

True. But is “normalization” the ideal response? What about fighting back? Citing a prison abolition conference she’d attended, Crane assured me that My Brothers’ Place personnel do, indeed, do “the radical stuff. But that’s our private stuff. We don’t jeopardize the house.”

I asked Crane how she got into this line of work.

“Well, I’ll tell you ... last year, we had an article written about us in the paper. And the reporter asked, ‘Isn’t it odd that the staff is predominantly female, when the residents are all men?’ And I said ‘No. Because what we’re trying to do here is the same kind of consciousness-raising that the women’s movement did. It’s our history of liberation, of expanding consciousness, that we’re trying to give the men.’ Women are committed to



certain kinds of philosophies and values. And that’s why I’m here.”

Former director of counselling Bonnie Burstow, ex-staff member Kali Grower and ex-board member Sandra Carpenter-Davis are committed to a different set of philosophies and values – and that’s why they’ve left.

Burstow told me that, when the house was first set up, “the staff was supposed to understand oppression. The house wasn’t going to be run like other halfway houses. It was supposed to be a place of empowerment for the residents. When I first considered becoming the director, I told them that I only wanted to work in a collective situation, and they agreed. One week before my interview, I talked with them about a sit-in I’d done with the Coalition to Stop Electroshock at the office of the minister of health. They had no problem with my radical orientation at that time. But after a while, and in spite of the house’s successes, the board

started discouraging radical stances and, finally, empowerment became a word with no meaning.

“We had a team approach. Everybody was responsible to each other. And the men also operated as their own decision-making team. But some of the pro-psychiatry staff members didn’t want to make decisions as a team: they wanted to do their own thing. And they claimed that the collective was a failure, because their opinions were not being taken to heart.”

The existence of the collective was never formally recognized. Some board members claimed that a more hierarchical staff structure was needed to placate funders. But Burstow says the funders knew there was a collective, and were not complaining – the house was working well.

Heterosexism became an issue in the later stages of the conflict. Grower tells of a gay resident who fought with his lover, put his hand through a piece of glass, and was

taken to the Don Jail. "There was a great deal of hostility. People were saying things like, 'Look what he's done; we don't want him back,' and 'What will the community think?' Another resident threw a chair at one of the guys, and hit a staff member hard enough to cause a partial hearing loss. But that was no problem — the staff member said we should give him another chance. This resident was 'straight.'

"There was a clear difference in how gay residents were treated. Some staff would be hostile every time a gay resident was mentioned. We were told to show them the other side — heterosexuality. If we focused on their coming out of the closet, or if we were supportive of their gay relationships, it was suggested that we weren't giving them the opportunity to explore their sexuality."

The mass resignations were directly precipitated by an incident in which a couple of staff members body-searched men suspected of bringing drugs into the house. This act, as Burstow says, "amounted to treating the guys as if they were still in prison." Burstow and Grower's strong objections both to the body-searches themselves, and to how the incident was later dealt with, led to a clash that ended in their permanent departure from My Brothers' Place. Several other staff and board members, including Carpenter-Davis, then resigned in solidarity with them.

The anti-psychiatry issue, according to Burstow, was at the core of the conflict at My Brothers' Place: "There was increasing opposition to the house endorsing activities of the Coalition to Stop Electroshock. Some board and staff members felt that not liking psychiatry was being part of a crazy ideology, and that we were being irresponsible. There were staff members suggesting to residents that they 'up their meds,' and then being horrified when we said that this was hurting the guys, not helping them."

They felt, adds Grower, that, "by not encouraging the men to seek psychiatric help for their problems, we were denying them appropriate treatment."

Burstow describes the reaction of a new administrative director to a resident's suicide attempt as "really telling. It looked like the hospital was going to get control of him, and a number of us wanted to prevent that from happening. But her position, which the board supported, was, 'We are not here to rescue people from psychiatry.'

"I saw the writing on the wall one day, after a resident had quietly cried throughout a board meeting. I was told by the vice-chair that this man was in no shape to be in the house, much less at a meeting; that we could not operate with him there; and that we should get him into an institution immediately.

"They didn't want to see the reality. They didn't want a style they didn't approve of at the meetings. Ultimately, despite their radical words, they didn't want anything interfering

"If you scratch a liberal, you'll find a fascist. That's what we found at My Brothers' Place."

with the easy operation of the board. So, in the end, they became reactionary. They wanted people who looked like they had class representing the house. They didn't like people who talked too loud. That meant Jews, like me, and Native ex-inmates, like Bill Lewis."

Some board and staff members "felt that the house was becoming a vehicle for Bonnie's political ideas," says Carpenter-Davis. "They understood that prison is oppressive. But they didn't see that the psychiatrists trying to 'help' the guys were part of that oppression. They have not been psychiatrized, and don't understand. I do have a psychiatric background which, unfortunately, I let them know about. People later made snide

comments, such as 'Sandra isn't able to function; she's not together enough.' Blatantly trying to undermine my credibility." Burstow adds that "The use of psychiatric concepts was insidious."

When I talked with Crane, she said that ex-staff members, though they were very good people, had been suffering from the "errors in judgement and obsessiveness which are symptomatic of burnout," which she described as being like "an infectious disease that they all caught from one another." She also said they "could not discuss things rationally," and at one point described their thinking as "paranoid."

Grower feels that My Brothers' Place is going to become "just like every other halfway house. It will not be a safe place for ex-psychiatric inmates. People seen as 'acting out' will find themselves, and indeed *are* finding themselves, threatened with the Clarke [Toronto's infamous institute of psychiatry]." "There will be no political element at all," says Burstow. "Most of the men who come to the house have been on psychiatric drugs for years. Now they will remain on them. During our time, people got off the drugs, and did so successfully. To me, that's empowerment. That means no longer being doped up and at the mercy of the system. My Brothers' Place will still be a house that takes men who've been psychiatrized; but it will be part of the system that is hurting them, though it may pretend to operate differently.

"For all that, though," she adds, "the story of My Brothers' Place has been one of success. Men who had been gobbled up by the system, who had been floundering throughout their lives, have got back on their feet. For over two years, we operated a radical, empowering halfway house, and we did it well. In so doing, we have paved the way for empowering halfway houses in the future. And that is no mean feat."

According to Sam Wagar, one of the staff members who resigned, "The left wing at My Brothers' Place were true, consistent, ethical, radical

people, who told the truth – and scared the shit out of the liberals. Most of the time, if you scratch a liberal, you'll find a fascist. That's what we found at My Brothers' Place."

"It's really funny, you know," said Carolyn Crane toward the end of my conversation with her, "because, in principle, we are all in agreement with the stand of the people who left, but in practice ..." And she let the sentence trail off.

When I met with Bob, we decided to go sit out in the back yard, since it was a beautiful day. On our way there, we had to pass two staff members talking on the porch. Bob said "Excuse me," as he opened the door for us to go out, and the male staff member, without looking around to see who had spoken, stopped the conversation just long enough to say coldly, "I'm talking."

In trying to illustrate how the residents "run the house," Bob told me that they had a say in deciding who would or wouldn't work there – so the staff was friendly. When I mentioned that the guy on the porch hadn't seemed overly friendly, Bob said, "Oh, he just doesn't like anyone bothering him while he's talking ... I guess it's important, what he's got to say."

Bob doesn't know how long he will be at My Brothers' Place. He told me that he'll have to be careful when he gets out, because he "misused" two months' disability cheques while at the house: although officially the money was his, it was not his "privilege" to spend it. But he did – so he won't be getting cheques for two months after he gets out. He doesn't know how, or where, he will live.

Bob called me several days after our interview to say that he is going to try to fight against having to take Modecate. I'm glad he's not resigned to blindly accepting the constraints placed upon him by the corrections system and the psychiatric industry. Too bad no one at My Brothers' Place is likely to help him find his way out.

MAD NEWS

Somewhere for women to go
Toronto's Wilhemina Nolan has presented the idea for Project Esperance ("esperance" means "hope" in French) to Ontario's ministries of housing and of community and social services. The project, which would cost almost \$10 million, would provide non-profit housing, and support services, for women who are being beaten by their partners and have nowhere else to go. Nolan herself recently left an abusive relationship, taking her year-and-a-half-old baby with her, and the near impossibility of finding affordable housing made her want to do something concrete for other women in her situation. The government's response to Nolan's proposal remains to be seen.

Good news for eccentrics
Eccentrics are happier, healthier and longer-lived than conformists, says psychologist David Weeks, who has studied the subject in Britain and the US. According to the *Toronto Star*, Weeks "hopes to familiarize mental health workers with eccentricity as a condition distinct from mental illness" in order to prevent people "from being wrongfully committed to mental hospitals when they are simply eccentric." *Phoenix* wishes Weeks the very best of luck in this endeavour.

Available now, from the Madness Network

The *Madness Network News* (MNN) folks, though unfortunately no longer publishing their excellent journal, are still offering the following publications for sale (all orders must be

prepaid in US dollars, and donations are tax-deductible):

Dr Caligari's Psychiatric Drugs, third edition, copyright June 1987. One of the few unbiased sources of information about the harmful effects of psychiatric drugs; also deals with informed consent, overdosing, drug withdrawal and general precautions. All-new section updating each drug category. Written by a Berkeley MD. \$6 each, postpaid, or \$4 each for orders of five or more. Available from the Network Against Psychiatric Assault, 2054 University Avenue, Room 405, Berkeley, CA 94704.

Back issues of MNN (\$1.25 each); the *MNN Reader* (a large and beautifully illustrated collection of articles and poetry from the early days of the movement, copyright 1974, \$7); *Bibliography on Psychiatry as Social Control* (an annotated list of books, compiled by ex-inmate reviewers, \$2.50); "Psychiatry as a tool of repression" (political analysis by Jenny Miller, reprinted from *Science for the People*, \$1.50); the Shock Packet (a collection of first-person accounts by shock victims and articles about the harmful effects of, and the campaign against, ECT: \$2.50); "Psychiatry is Social Control" bumper sticker (\$1.75); "Caution: Psychiatry May Be Hazardous to Your Health" or "Avoid Freud" button (\$1.25 each). Available from *Madness Network News*, 2054 University Avenue, Room 405, Berkeley, CA 94704.

Coming soon: *Volume 7, Number 2, with lots more news.*

SHOCK WAVES

Linda André vs The ECT Industry

Dear Phoenix,

I am enclosing a copy of a complaint that was filed here in New York on April 20, 1987. This is a landmark case. Just to get a shock case to court is a major achievement (it took me two years of full-time searching to find a lawyer). But this is not a typical shock case, which complains only that some bones were broken, or that unilateral should have been used instead of bilateral, or that there were unusual circumstances in this case. We are saying that shock is not safe for anyone, ever, and that to use it at all is wrong. We are asking for one hundred and ten million dollars, which could never make up for the damage that has been done. The purpose of bringing this suit is to put shock "treatment" on trial. Whether we win or lose, we are going to fight the shrinks to the end.

I think it's important for your readers to know about this case and to follow it as it develops. We hope to set a precedent so that a landslide of shock cases will follow, and we think all shock victims everywhere will be heartened by this news.

In solidarity,

Linda André
New York

André has filed her complaint against Somatics, Inc.; Mecta Corporation; Medcraft, Inc.; the New York Hospital; Julie Hatterer, MD; and Thomas Kramer, MD. Somatics, Mecta and Medcraft manufacture the shock machines used on André in the New York Hospital, where she was

incarcerated in 1984. Kramer and Hatterer were her shrinks.

The complaint states that electroconvulsive therapy (ECT) is neither safe for use upon, nor an effective therapeutic mode of treatment for, any person, and that it caused André to sustain "serious and severe per-

manent personal injuries," including memory loss and impairment of mental functioning.

The causes for action against the three manufacturing companies are:

- that the ECT devices "were improperly and unsafely labeled, were sold with instructions that were hazardous and unsafe when followed and failed to include proper, reasonable and adequate warnings of the dangers inherent in the use of the devices";
- that the devices were dangerous when used for the purposes intended;
- that André was caused to sustain injuries and damages for which the manufacturers are liable;
- that the manufacturers "were negligent in the research, design, manufacture, sale, labeling, advertising, field support, and failing to recall the devices," and had "breached their duty to exercise reasonable care" in all these areas; and
- that warranties stating that the devices "could be safely used without unreasonable hazard and without unreasonable risk of injury to the recipient of the ECT therapy" were breached by the manufacturers.

The causes for action against Hatterer, Kramer, and the New York Hospital are:

- that the doctors "failed to conform to good and accepted practice of psychiatry in the treatment of Linda André";
- that they were negligent in their treatment of her, and that their negligence "consists in but is not limited to" failing to "reasonably and properly" diagnose her, evaluate her, and prescribe a "proper treatment regimen" for her, by "prescribing, advising and administering ECT treatment which was contraindicated";
- that they were guilty of "malpractice based on lack of informed consent," since they failed to tell André, about alternatives to ECT and about the "reasonably foreseeable risks and benefits involved"; and
- that "a reasonably prudent person in [André's] position would not have undergone the treatment if she had been fully informed."

Phoenix wishes André well in this potentially precedent-setting suit.



Shock Demo

The Ontario government and Ontario psychiatrists continue to spread lies about shock. (See "Ontario Shock Lies Imported from US," page 25, and "Damned Lies and Shock Statistics," Volume 6, Number 4, for details of the very similar Ontario version, which is based on the APA "guidelines.") The final draft of the Ministry of Health's latest shock "guidelines" hasn't yet been written, but copies will be distributed to staff and inmates of the province's ten psychiatric institutions this year.

The "guidelines" lie primarily by omission, failing to mention the fact

that the use of shock is controversial, the epileptic seizure always induced by shock, and the brain damage that shock invariably causes. They also falsely claim that permanent memory loss is "rarely" a result of shock, and that shock is safe and effective.

To combat these lies, the Ontario Coalition to Stop Electroshock held a protest demonstration May 8 (during "Mental Health Week") in front of Toronto's notorious Queen Street Mental Health Centre. About 25 shock survivors and supporters demonstrated for two hours, leafleting and talking with the public, some





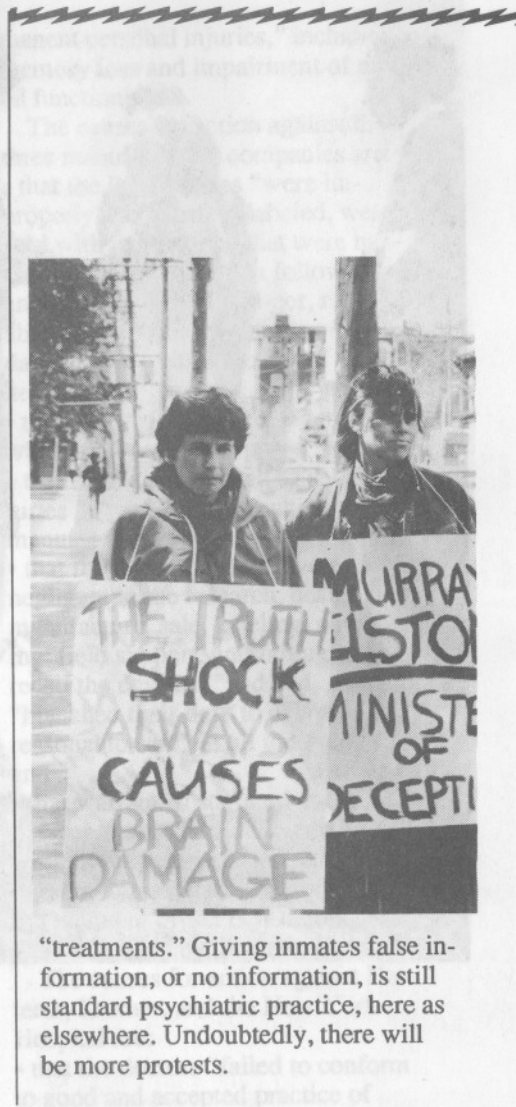
Queen Street inmates and ex-inmates, and the media.

Coalition spokesperson Don Weitz blasted the ministry for being “a bunch of wimps in league with psychiatry.”

Shock survivors Dorothy Kent and Keith Welch also spoke out. Kent said that, after being forcibly subjected to 21 shocks in 1955, she lost her job, and her family life was ruined.

Welch lost his photographic memory after 53 shocks administered for “suicidal tendencies” in 1978 ... which caused him to become more suicidal than he had been before.

Neither of these people was warned about the permanent memory loss and brain damage always caused by shock – just as today’s inmates are not warned or adequately informed about shock and other



“treatments.” Giving inmates false information, or no information, is still standard psychiatric practice, here as elsewhere. Undoubtedly, there will be more protests.



Ontario Shock Lies Imported from United States

Marilyn Rice of the Committee for Truth in Psychiatry (CTIP) has written to *Phoenix* about the Ontario Ministry of Health's "patient information guidelines" for ECT (see "Damned Lies and Shock Statistics," Volume 6, Number 4). Apparently, the guidelines are based on the "informed consent" statement that the American Psychiatric Association (APA) is trying to get the Food and Drug Administration (FDA) to sponsor for all US "patients."

The APA's proposed statement includes the standard garbage about shock being painless, safe and effective, as well as the requisite ass-covering: "ECT, like any other medical or surgical procedure, involves a certain amount of risk." "Fatalities are very rare." "Over the course of treatments, confusion and memory difficulties often develop." "Problems with memory ... tend to fade with time." "There is a possibility that occasionally a mild degree of loss may persist, and that rarely, more pronounced memory deficits may occur."

"The majority of patients treated with ECT do not find these memory changes of great importance.... Other patients, for reasons that are not yet fully understood, have continued to complain about their poor memory function for prolonged periods of time."

"Although the results of treatment are usually gratifying not all cases will respond equally well ... [some] may fail to respond at all."

Rice also enclosed a summary of the FDA's regulatory proceedings concerning shock, and CTIP's resistance, excerpted here: In 1979, the FDA classified shock machines as Class III, which earmarks a device or procedure for a safety investigation, and announced that it was considering developing an "informed consent" statement for prospective ECT "patients." In 1982, the APA petitioned for reclassification to Class II, and submitted a peti-

tion that ECT was and always had been a safe treatment. In 1983, the FDA published a "notice of intent" to reclassify, inviting public comment (most of which was opposed to the reclassification).

In 1984, the Committee for Truth in Psychiatry, an organization of people who have undergone ECT, formed to participate in these proceedings, in order to see that people are truthfully informed about shock before deciding whether to consent to it. CTIP presented its own proposal for an informed consent statement to the FDA, stating that shock always causes brain damage and permanent memory loss.

In 1986, under CTIP auspices, more than 100 victims of ECT individually petitioned the FDA for CAT scans of their own brains, to show the effects of shock. In the same year, the FDA rejected CTIP's informed consent statement (giving CTIP permission to resubmit the proposal if information to support it "comes to light").

What the FDA would like to do now is deny all petitions for an investigation and take the next formal step toward reclassification: publishing a "proposal to reclassify" in the *Federal Register*. This has so far been prevented by the watchful eye now being cast on these proceedings – primarily by state protection and advocacy agencies.

Whether the FDA will ultimately reclassify or investigate depends on public sentiment. Obviously, decisions of this kind made in the US will affect psychiatric inmates in Canada as well. Express your views to: Mr John Vilforth, Director, Center for Devices and Radiological Health, FDA, 5600 Fishers Lane (HFZ-1), Rockville, MD 20857, RE: Docket Number 82P-0316 (ECT).

The Committee for Truth in Psychiatry can be contacted at Box 76925, Washington, DC 20013, or by phone at (703) 979-5398.



You can get a free copies of the "ECT Guidelines" by writing to: Ministry of Health, Health Information Centre, 9th Floor, Hepburn Block, Queen's Park, Toronto, Ontario M7A 1S2. We urge our Ontario readers to write letters of protest to Minister of Health Murray Elston and to your MPP.

RIGHTS & WRONGS

Bill 190 Update

Donna Lyons looks at amendments to Ontario's Mental Health Act

Ontario inmates deemed "competent" have won the right to refuse psychiatric "treatment" with the passing of Bill 190, the *Mental Health Amendments Act*, on June 29, 1987.

The Ministry of Health changed its position three times with respect to amendments to the *Mental Health Act*. First, a provision that would give a "competent" involuntary inmate (or the legally authorized substitute of an inmate found "incompetent,") the absolute right to refuse psychiatric "treatment" was included in Bill 7, the *Equality Rights Statute Law Amendment Act*. Bill 7 was introduced to bring existing provincial legislation into line with the equality rights provisions of the Canadian *Charter of Rights and Freedoms*.

Bill 7 received royal assent on December 18, 1986. The ministry announced, however, that it was holding back Section 35(4)(a), the "mental health" provision of the bill, until April 1, 1987, presumably because of the strong opposition to the proposed amendment from the Ontario Psychiatric Association and the Ontario Medical Association. But this provision did not pass into law on April 1. It was held back again, supposedly until June 1. In the end, it was superceded by provisions contained in Bill 190.

Bill 190 was strongly opposed by civil rights and inmates' rights advocates (see "Ontario's Attack on Our Rights," Volume 6, Number 4). In its original form, it included a provision that would have allowed psychiatrists to forcibly "treat" outpatients and former patients! At public hearings in June 1987, the Standing Committee on Social Development heard representatives from many groups concerned with inmates' rights (see

Bill 190 was opposed by civil rights and inmates' rights advocates.

"Phoenix Mouths Off," page 28).

In the last days of the public hearings, as a result of the strong and well-organized presentations of inmates' rights advocates, the ministry again changed its mind, and the provisions that finally passed into law do give a "competent" involuntary inmate the right to refuse psychiatric "treatment."

Unfortunately, in the case of "incompetent" involuntary inmates, a substitute decision-maker's refusal can still be overridden by a review

board. Some of the changes to the act are outlined below.

"Treatment"

ECT and other psychiatric "treatments" cannot be given to an inmate without her or his consent – unless she or he has been found not "competent" to consent to "treatment." A finding of "incompetency" to consent to "treatment" can be challenged. A substitute decision-maker can refuse ECT or psychosurgery, and this refusal cannot be overridden. A substitute decision-maker's refusal of other psychiatric "treatments," however, can be overridden by a review board in the case of involuntary, LGW (Lieutenant Governor's Warrant), or remand inmates. The review board must be satisfied that LGW or remand inmates satisfy involuntary committal criteria before a "treatment" order can be made (actual certification is no longer necessary).

In "emergency situations," psychiatric "treatment" can be given to an inmate without a valid consent or a "treatment" order being made, if the psychiatrist certifies in writing that the life of the inmate is at risk and "treatment" is immediately necessary.

Appointing a representative

Any person over the age of sixteen and presumed "mentally competent" to do so may appoint a representative to refuse "treatment" on her or his behalf in the event that a subsequent finding of "incompetency" is made. The representative may also consent to the disclosure or examination of the person's clinical record. All inmates must be notified of their right to appoint a representative. Pre-printed forms are available at Ontario psychiatric facilities (Form 44 under the *Mental Health Act*). A written and witnessed statement, however, is all that is required under the act. (See inside front cover for sample statement.)

A "competent" person can revoke the appointment of a representative and appoint someone else, in writing, at any time. Dating the appointment form will help prevent confusion if an appointment has been revoked and a new representative appointed. A

patient advocate or rights advisor can help you complete the statement required in order to appoint a representative.

The appointment form should also indicate your wishes concerning "treatment." For example, it might indicate that you do not want ECT or drugs, and set out alternatives, such as "talk therapy" or "exercise therapy," which have proved beneficial in the past. It might also include statements regarding past "treatment" experiences that have been particularly harmful.

If you are not presently incarcerated, you should get a doctor's statement indicating that you are "competent" to appoint a representative and make "treatment" decisions. In the event of a future incarceration, your wishes when "competent" would be hard to dispute. You and your lawyer should each keep a copy of the statement. Your representative – who should be over sixteen, "mentally competent," and available and willing to act on your behalf – must also have a copy.

If you are found "incompetent" to appoint a representative, you must be notified of this finding. While a finding of "incompetency" to appoint a representative cannot be challenged or reviewed, you can apply to your review board, which may appoint a representative on your behalf, if you consent to the appointment and if it is, in the opinion of the board, in your "best interest" that the appointment be made. If you are found "incompetent" and the board does not make an order appointing a representative, a relative or your official guardian must be approached to consent on your behalf.

Substitute decision-making

The act has been changed so that a "committee of the person" (appointed by the court under the *Mental Incompetency Act* – usually a relative who takes control of the inmate's financial affairs, or is officially allowed to decide where the inmate will live), the inmate's personal representative, or the inmate's official guardian may give or refuse consent on behalf of an "incompetent" inmate in certain circumstances, instead of the in-

mate's "nearest relative." These changes make it difficult for physicians to use the substitute consent hierarchy as a "shopping list" for a consent to psychiatric "treatment," looking around for someone else to give consent if one person refuses. If two or more persons claim authority to give or refuse consent, the claim of the highest ranked person prevails; a personal representative appointed by the inmate is ranked higher than a relative. A refusal prevails over a consent when two persons are of equal rank.

The decision of a "committee of the person" overrides any other possible substitute decision-maker's refusal, including the decision of a personal representative.

A substitute decision-maker must

If you are not presently incarcerated, you should get a doctor's statement indicating that you are "competent" to appoint a representative and make "treatment" decisions.

make decisions based on your wishes, where known, and in accordance with your "best interests" if your wishes, when "competent," are not known. Factors to be considered in determining whether a particular "treatment" is in your "best interests" include the supposed likelihood of "substantial" improvement with "treatment," or improvement without it; whether the "benefits" are seen to outweigh the risks involved; and whether it is seen to be the "least restrictive and intrusive method possible in the circumstances." This suggests that alternatives to the requested "treatment" method, including no "treatment," must be discussed with a substitute decision-maker before a

valid consent to, or refusal of, "treatment" can be given.

Your "nearest relative" must then state in writing his or her relationship to you, that he or she has been in contact with you over the preceding twelve months, and that he or she is willing to assume responsibility for giving or refusing consent and is unaware of a relative with more authority to act on your behalf.

"Competency"

You can be found "incompetent" to refuse (or consent to) "treatment," examine your clinical record, manage your financial affairs, or appoint a representative. You may challenge a finding of "incompetency", except in regard to appointing a representative, by applying to your review board. Review board decisions can be appealed to the District Court and, subsequently, to the Court of Appeal.

If you are under sixteen, a physician or review board may deem you "competent" to refuse "treatment." But there is a presumption under the *Mental Health Act* that a person under sixteen is not "competent" either to consent to or refuse "treatment." If you are sixteen or over, there is a presumption of "competency" until "incompetency" is determined.

Obviously, there are still serious problems with Ontario's mental health law. A psychiatrist can find an involuntary inmate "incompetent" if the inmate refuses "treatment." A review board can override a substitute decision-maker, even when the wishes of the inmate are known. And a review board is required to act in the inmate's "best interests" rather than on her or his wishes as expressed when "competent."

Furthermore, concerned friends or family members of inmates found "incompetent" to refuse "treatment" because medication or ECT "treatments" have rendered them incapable of providing a valid consent cannot apply for a review into whether such inmates are, in fact, "competent" to refuse "treatment."

All in all, however, the changes to Ontario's mental health legislation make it the most progressive in Canada.

Phoenix Mouths Off

Excerpts from the testimonies of Ryan Scott and Irit Shimrat at the public hearings on Bill 190

Ryan Scott:

It appears as if the *Charter of Rights* has been burned. It was certainly totally disregarded in drafting Bill 190. This bill allows psychiatrists to forcibly "treat" anyone they deem "incompetent." Let us make clear what psychiatrists mean by "treatment." They don't mean simply having a pleasant little chat about your difficulties. They mean filling you full of mind-altering drugs. The most popular drugs among the psychiatric set are the neuroleptics. The *Physicians*

Desk Reference

lists dozens of side-effects from these drugs, among them sudden death. In 1980, Aldo Alviani died suddenly at the Queen Street Mental Health Centre, at the age of nineteen, as a result of the forcible administration of neuroleptics. His death by "therapeutic misadventure," as the coroner quaintly put it, was not unique. Many people die under the tender ministrations of psychiatry, while on adventures they did not willingly embark upon.

I was almost one of them. At the age of fifteen, I was confined to Ontario's pre-eminent psychiatric teaching hospital, the Clarke Institute of Psychiatry. Although a minor, I was incarcerated on an adult ward. Within a few hours of arriving, I was injected with a large amount of a neuroleptic. I was not informed of what the drug was intended to do, nor of what side effects or risks were involved. In short, neither I nor my parents were consulted. Almost immediately, I became confused and disoriented, and could not stand up or indicate that I needed help. My breath-

ing started to fail and I fell unconscious. To save Canada's premiere teaching hospital embarrassment (and, incidentally, to save my life), a staff member acted quickly and injected another drug to counteract the effect of the first. My parents were initially told by the staff that I'd had an allergic reaction. When they questioned that explanation, the doctor admitted that perhaps he had misjudged the dosage.

I remember my father entering the room in which I was confined and

viously at times like this.

Surely the decision to take the risk of being pumped full of powerful drugs should be made by the person affected – the person whose mind and body may be permanently damaged – and not by psychiatrists who have their reputation as practitioners of science to uphold, and their living to make, by treating "patients."

Psychiatrists have perceived Bill 7 becoming law as a threat, and have brought great pressure to bear on the government to enact Bill 190. We

should remember that Bill 7 was meant to bring the *Mental Health Act* into line with the *Charter of Rights*. Isn't it odd that rights for their "patients" are perceived by psychiatrists as a threat to their power?

Power is a major issue here. Doctors

have the power to influence governments to enact legislation. Their will becomes law. Their "patients" do not have that power. We can rarely influence, or even access, the judicial or legislative system. Inmates are not a pressure group. This arrogant, dictatorial piece of legislation fails to address the tremendous power imbalance between psychiatrists and those subject to their control. The majority of psychiatrists are white, middle-class males. Those whose bodies and minds they seek to control are frequently women, minorities, and the poor.

When individuals are confined against their will, whether the purpose is supposed to be treatment, rehabilitation, or simply punishment, it is imperative that their human rights not be further violated.

Under Bill 190, people espousing unpopular political beliefs who run

Isn't it odd that rights for their "patients" are perceived by psychiatrists as a threat to their power?

screaming about chemical straight-jackets. He was told that it was obvious that I was afraid of him and that his presence was untherapeutic, and he was forbidden to visit me again. I was terrified. I felt helpless and abandoned, and feared that, if they didn't kill me, they were sure to permanently damage my brain. Although my fear was justified, I was labeled paranoid schizophrenic, and this was used as an excuse for further "treatment" and incarceration. I was told I would be schizophrenic for the rest of my life. I was also told that I should quit school, even though I was an honours student with an average in the high nineties. Luckily, I had learned not to believe everything I was told, and I quickly learned how to lie for self-preservation. The good doctors, their egos sufficiently stroked, eventually let me out. I've never looked back, except ner-

afoul of the law may end up remanded to a psychiatric hospital, their competent refusal of treatment disregarded, and forcibly administered dangerous drugs, all by the state, in the name of therapy.

Irit Shimrat:

Forced treatment creates helplessness, panic and rage. Force is not conducive to faith, and faith is all that can make psychiatric "treatment" work.

The shrinks always tell you that you're going to thank them for this when you get better. And the fact is that, until you're thanking them, they're not going to let you out. So you learn how to lie; how to disguise your rage.

Before they release you, they have to deem you competent. Bill 190 defines "competency" as requiring that the "patient" understand the nature of her or his "illness" and the nature of the "treatment" proposed. This means knowing that you're not ill and that the so-called "treatment" to which you may be subjected is dangerous is sufficient grounds for being deemed "incompetent." In activist Brian McKinnon's accurate analysis, "competency is just a pretty word for compliance."

A psychiatrist can deem you incompetent if you disagree with anything he or she says, or if he or she doesn't happen to like your race, your politics, your sexual orientation or any aspect of your behaviour.

As for the idea that "mental patients" are more dangerous than their captors, this is absurd. One need only observe the practice of institutional psychiatry to see clearly that the sole purpose of all psychiatric "treatment" is to crush the will and induce passive conformity. People who've been in the hands of psychiatrists for any length of time often can't fight their way out of a paper bag, much less endanger themselves or others.

Many who survive neuroleptic "treatment" suffer from irreversible brain damage, including tardive dyskinesia. This condition is characterized by uncontrollable convulsions of the face and limbs, sometimes ac-

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accompanied by drooling and other unsightly manifestations which, by making you look crazy, seriously impair your ability to find housing, employment, or social acceptance.

The idea put forward by psychiatrists that "mental patients" whom they are not allowed to forcibly drug will be warehoused and languish without "treatment" is equally ridiculous. My own experience at Branson Hospital in North York and Mount Sinai in Toronto would certainly not have been the near-fatal nightmare it was had neuroleptics not been forced on me. In fact, if I had been locked up and talked to, rather than locked up, sat on, tied down and shot full of drugs, I might even have been fooled into thinking someone there wanted to help me.

In 1980 Dr Roxanne Bukari at Mount Sinai told me that if I didn't

Knowing that you're not ill and that the so-called "treatment" to which you may be subjected is dangerous is sufficient grounds for being deemed "incompetent"

take neuroleptics for the rest of my life, any time I was under stress I would have another "psychotic episode." I have no doubt that, if I had believed this, I would have tardive dyskinesia now and would be locked up in a provincial facility for hopeless cases. Being in the care of shrinks and their minions is by far the most horrifying thing that has ever happened to me. Any stress I have experienced since is negligible

in comparison.

Psychiatrists are cops and jailers, whose tools of oppression are electrical torture and nerve poisons, rather than bludgeons and guns. Why should the psychiatric and pharmaceutical industries be protected at the expense of the people they are supposedly helping?

More Rights and Wrongs

Rights of the Disabled: Teleconference 1987

The Resource, Educational and Advocacy Centre for the Handicapped (REACH) is presenting a course called "The Rights of the Disabled," for the sixth consecutive year, with the cooperation of the University of Ottawa, Continuing Education. The course provides information for disabled people, those who work with and care for them, and families and friends of disabled people. According to the press release, "Anyone dedicated to advancing the rights of the disabled would find the course extremely beneficial." It is offered from October 25 to November 29, 1987, 1:30 to 3:30 Sunday afternoons. Lecture topics include mental health law; human rights legislation; rights of the institutionalized; wills, trusts and taxation; employment and consumerism; and social assistance programs. All facilities are completely accessible to all people. The course costs \$40 for six lectures. The cost of attending a single lecture is \$12. The University of Ottawa will provide a receipt for tax credit purposes. For more information, contact Christine Clark (course coordinator) at (613) 236-6636, or at REACH, 309 Cooper Street, 2nd Floor, Ottawa, Ontario K2P 0G5

Inmate dies on psych ward

Twenty-one-year-old Brian Netrefa was admitted to the psychiatric unit of Alberta's Red Deer Regional Hospital Centre on November 12, 1986 because of an alcohol and drug

abuse problem. Eight days later, he died of cardiac arrest. According to a report in *The Calgary Herald*, an autopsy showed significant traces of Anafranil, an anti-depressant drug, in his blood. Netrefa had also been taking Parnate, another anti-depressant. The combination of these two drugs can lead to raised blood pressure, tremors, convulsions, an increase in body temperature and, finally, death. Psychiatric nurse Robert Young said Netrefa didn't get the Anafranil from hospital staff: "It's possible for a patient to keep medicine and pass it on to another patient." An inquiry is currently underway.

Culhane allowed in prisons

Prison activist Claire Culhane, barred from BC provincial prisons since 1978, has won the right to go back in. She was never given a reason for being barred. In return for her renewed visiting privileges, she agreed to withdraw from an impending BC Supreme Court lawsuit (based on the *Charter of Rights'* guarantees of equal treatment under the law and of freedom of expression and association) against Attorney General Brian Smith. She hopes that she will also now be able to visit high-security federal prisons in BC. Culhane, the head of the Prisoners' Rights Group, has written two books on prison reform: *Barred From Prison: A Personal Account*, and *Still Barred From Prison: Social Injustice in Canada*.

Sex and psychiatry in the US

Two thirds of psychiatrists surveyed by a group of Harvard University psychiatrists reported treating "patients" who said they were sexually involved with other therapists. Those surveyed turned in their colleagues for unethical sexual behaviour in less than ten percent of these instances. Dr William L Webb Jr, chairman of the Ethics Committee of the American Psychiatric Association, opposes mandatory reporting on the grounds that it might not always be "in the patient's best interest."

PHOENIX PHARMACY

Neuroleptic Malignant Syndrome: A fast and horrible way to die

We've always known that psychiatric drugs can be deadly. The neuroleptics ("major tranquilizers" or "anti-psychotics") such as Haldol, Thorazine, Stelazine, Mellaril and Modecate, to name a few, have been causing suffering and death for a long time: "sudden death" is officially acknowledged as one of the possible "adverse effects" of these drugs. Recently, we discovered Neuroleptic Malignant Syndrome (NMS), first described in medical literature about 20 years ago. NMS is not as rare as most psychiatrists once assumed. And it can kill you. (See "Phenothiazine-related deaths," Volume 2, Number 4.)

In an article published in the October 1986 *American Journal of Psychiatry*, three psychiatrists reported that at least 1.4 percent of a group of psychiatric inmates surveyed developed NMS while on neuroleptics. The psychiatrists admitted that they had probably underestimated the incidence rate, which could be as high as five percent. The death rate for NMS is even more alarming: once you develop it, your chances of dying of it are about one in four. The report mentions a 23-year-old man who had been on Stelazine for seven months prior to his incarceration. Six days after admission, he died of NMS. According to an editorial/background paper in the same issue, the onset and progression of NMS can be "explosive," and

death usually occurs within three to 30 days.

The main symptoms are muscular rigidity and high fever. Symptoms can start anytime, regardless of dose, and may include "lead-pipe rigidity"; "flexor-extensor posturing"; "oculogyric crisis" (your eyeballs are stuck in one position for minutes or hours); "retrocollis" (neck spasms in which your head is drawn backward);

**NMS is not
as rare as
most psychia-
trists once
assumed. And
it can kill you.**

"festinating gait" (involuntary, short, accelerating steps); "choreiform movements" (involuntary, jerky bodily movements); "dysphagia" (difficulty swallowing); "trismus" (partial paralysis of mouth or jaw, like lock-jaw); "opisthotonos" (body spasm in which your head and heels are bent backward and your body bent forward, like a bow).

These central nervous system horrors are bad enough, but there are

autonomic nervous system effects as well: hypertension (high blood pressure); rapid heartbeat (over 30 beats per minute), rapid breathing (25 or more respirations per minute), and profuse sweating. You can also become delirious or stuporous, or go into a coma.

Although a drug called Dantrolene can help relieve the muscular stiffness and spasms and lower the fever, there is no cure for NMS.

Every person taking a neuroleptic is at risk, but NMS primarily affects people less than 40 years old. At least 100,000 Canadians are now on neuroleptics. If we accept the 1.4 percent incidence rate as a conservative estimate, we must assume that at least 1,400 Canadians have or will soon have NMS. And a 25-percent death rate means that 350 will die, horribly and needlessly, as the result of this psychiatrically-manufactured disorder. We'll probably never know the exact number of NMS cases or deaths in Canada, since provincial ministries of health don't bother reporting causes of death or publishing them in their "mental health" statistics – and since NMS is frequently misdiagnosed, or completely ignored. (Leonard Frank estimates that, in the United States, as many as 4,200 Americans die of NMS each year.)

To find out more about the dangers of "medication," read *Dr Caligari's Psychiatric Drugs*, by David L Richman *et al* (San Francisco: Network Against Psychiatric Assault, 1984) – the most outstanding, easy-to-read and truthful booklet about psychiatric drugs, and how to withdraw from them (see page 21 for ordering information). Another excellent, hard-hitting exposé of the neuroleptics and anti-depressants is *Psychiatric Drugs: Hazards to the Brain*, by Peter Breggin (New York: Springer Publishing Co, 1983).

Meanwhile, be warned. If you're on neuroleptics, be sure to ask your doctor about NMS and other major drug risks, such as tardive dyskinesia. Better yet – don't continue taking neuroleptics. And if you're not taking any, don't start. *You could save your life.*

– Don Weitz

REVIEWS

Insanity: The Idea And Its Consequences, by Thomas Szasz

Review by Duff Waring

It has been 26 years since the publication of Szasz's first tirade against institutional psychiatry. In *The Myth of Mental Illness*, he presented a conceptual analysis of the term "mental illness" and an ethical critique of the treatment practices it generates. This latest book continues, without significantly extending, that analysis and critique.

The contentions are long since familiar. "Mental illness" is an illusory metaphor. It is not a medically provable phenomenon. The myth that it rests on the muddle of taking literally concepts that can only be used metaphorically. There is no evidence of bodily disease that would give the term "mental illness" a literal meaning.

Szasz defines illness in the same way a pathologist does: as a structural or functional abnormality of cells, tissues, organs or bodies. A genuine bodily illness is an expression of cellular derangements, and has physical symptoms.

Most people labeled mentally ill behave in socially unacceptable ways, or speak in ways that are confusing to others. They may be distressed, but their brains are not physically abnormal in any way. Szasz does not deny the existence of social deviance – he simply refuses to misplace it in the category of disease.

"Mental illness" is a ghost in the machine. A psychiatrist can only observe and evaluate behaviour. That evaluation legitimizes coercive psychiatric intervention.

The *melange* of disorders in the *Diagnostic and Statistical Manual* (DSM III) illustrate Szasz's claim that the most conspicuous feature of the criteria for "mental disorders" is their all-inclusiveness. The authors of DSM III themselves admit that there is "no satisfactory definition that specifies precise boundaries for the concept of mental disorder."

The only legitimate reason for state intervention in a competent person's life is to prevent harm to others. The person's own welfare is not the state's business. When people are competent to make their own decisions and appreciate the consequences, the fact that their lifestyles may be confusing or distasteful to others is beside the point. Crime is the business of the police and the judiciary. Involuntary committal and forced treatment are tyrannical responses to people breaking, not the law, but the norms of language and behaviour.

Institutional psychiatry ostensibly represents the humane concern of the liberal welfare state for those at odds with its psycho-social fabric. To Szasz, this betrays the repressive intolerance of an authoritarian demand for conformity.

Szasz is also at odds with the legal notion of insanity. Psychiatrists have no place in the courtroom. For Szasz, if the person knows what he is doing and appreciates the consequences of his actions, he is responsible for what he's done. An objectively provable disease, like epilepsy,

would negate criminal responsibility. But "insanity" does not fall within this category.

Szasz's writing is sometimes pedantic, and not brief. His scathing critical tone would be much more effective in concentrated doses. It wears thin as an extended exercise in belabouring a point that leaves the reader feeling the book is twice as long as it should be.

Szasz seems curiously intent on keeping the critical territory of anti-psychiatry to himself. He has nothing constructive to say about other anti-psychiatrists and, in particular, his caustic remarks about RD Laing are suspiciously venomous. He accuses Laing of "cherishing his medical identity" and courting "the approval of the medical profession" for his "particular brand of therapy."

But if Szasz finds the idea of cherishing one's medical identity so deplorable, why does he remain a Life Fellow of the American Psychiatric Association and a Life Member of the American Psychoanalytic Association?

"Mental illness" can be seen as an understandable response to unbearable circumstances. It can be a revelatory and possibly enlightening personal experience. It can also be an experience of intense personal suffering. Laing offers a radical therapeutic approach to "genuine psychic healing." This is precisely what Szasz does not offer. He admits that people labeled "mentally ill" suffer. But his work is confined to analyzing the label and criticizing both the labeling process and the treatment practices it generates. He does not confront the human reality of psychic suffering on its own terms.

It is no small achievement to expose the conceptual vagaries of institutional psychiatry. Though Szasz has been doing this for 26 years, he is not yesterday's news. As long as the proponents of institutional psychiatry wield the coercive power of incarcerating people in hospitals and drugging them against their will, we must continue to make their deficiencies clear.

Insanity: The Idea And Its Consequences
by Thomas Szasz. New York: John Wiley and Sons, 1987

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